Alberta Health Services

Alberta Health Services

2015-16 Annual Report

For more information about our programs and services, please visit
www.ahs.ca
or call Health Link at 811

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Letter of Accountability

Linda Hughes
Alberta Health Services Board Chair

I am pleased to present the Annual Report for Alberta Health Services (AHS) for the fiscal year ended March 31, 2016.

This report summarizes some of the important progress AHS has made over the past 12 months to build a high-quality health system that will be sustained for generations to come. This health care system doesn't belong to the AHS Board, or the Ministry of Health, or even AHS. It belongs to all Albertans and this organization is committed to delivering the quality care that all Albertans need and deserve. Since its inception in 2008, AHS has grown into a strong organization with a deep pool of experienced and dedicated health care leaders and an incredible team of staff, physicians and volunteers who daily pursue the objectives laid out in its Health Plan and Business Plan.

Together, we continue to foster an environment at AHS that's positive and patient-focused. We are building an environment that puts patients, families and our clients at the centre of everything we do, and involves them in decisions about their care. And we are building an environment that ensures staff, physicians and volunteers feel safe, supported and valued at work, so they can do their very best, every day, for the people we serve.

I am inspired by the work being done at AHS each day and I thank the dedicated teams who make this possible by their tireless commitment to the wellness of Albertans. Their accomplishments are evidenced in this report.

This Annual Report was prepared in accordance with the *Fiscal Management Act, Regional Health Authorities Act* and instructions as provided by Alberta Health. All material economic and fiscal implications known as of June 3, 2016, have been considered in preparing the Report.

Respectfully submitted on behalf of Alberta Health Services,

[Original Signed by]

Linda Hughes
Chair, Alberta Health Services Board

Message from the AHS President and CEO

Dr. Verna Yiu
President and CEO

This Annual Report shows the significant progress we've made over the 2015-16 fiscal year together with our valued partners in health. It includes improvements in how we deliver care, advances in technology and research, and our work to keep Albertans healthy and out of hospitals. We have also completed some important foundational work this year, to give clear direction and purpose for everyone who works within AHS.

In March 2016, AHS staff, physicians and volunteers finalized a new vision for the organization: **Healthy Albertans. Healthy Communities. Together.** It speaks to our shared desire – and our shared responsibility – for improving health, wellness and quality of life in the province, and it will inspire and unite our work. We've also developed four foundational strategies to help us build a workplace where staff, physicians and volunteers feel safe, supported and valued, so they can do their very best, every day, for Albertans.

- The Patient First Strategy
- Our People Strategy
- The Strategy for Clinical Health Research, Innovation and Analytics
- The Information Management/Information Technology Strategy

Together our vision and the foundational strategies support us in the strategic directions we outlined in the 2015-18 Health Plan and Business Plan: to bring appropriate care to communities, to partner for better health outcomes, and to achieve health system sustainability. This report illustrates the specific actions we've undertaken in the past year to meet those strategic directions and showcases our accomplishments and successes.

AHS was successful in reducing costs in 2015-16. Our expenses grew by only two per cent in 2015-16, which is significantly less than the historical average growth rate of over six per cent. Across all of AHS, there was a strong focus on managing resources effectively and efficiently while maintaining a focus on quality.

As we move into the next year, we will continue to work together with our valued partners in health – Health Advisory Councils, Provincial Advisory Councils, Wisdom Council, Patient and Family Advisory Group, health foundations and trusts, academic institutions, community-based organizations, local communities and the provincial government – to move toward the sustainable health care system we strive to be, with patients and families at the centre of every decision we make.

I am very proud to be part of this incredible organization. As I witness the work of the dedicated staff, physicians and volunteers of AHS, I am optimistic about the future of health care in this province. With their commitment and passion for health, we will continue to deliver safe, high-quality care every day.

[Original Signed by]

Dr. Verna Yiu
President and Chief Executive Officer
Alberta Health Services

Who We Are

AHS is Canada's first and largest provincewide, fully-integrated health system, responsible for delivering health services to more than 4.2 million people living in Alberta, as well as to some residents of Saskatchewan, B.C., and the Northwest Territories.

Being a provincewide integrated health care system allows us to share information, work seamlessly and provide standardized care to Albertans.

AHS cares for a growing and aging population with diverse needs. Alberta is the fastest-growing province in Canada. In 2015, Alberta's population growth rate doubled that of the national average (1.8 per cent and 0.9 per cent, respectively). As we age, we depend more on the health care system.

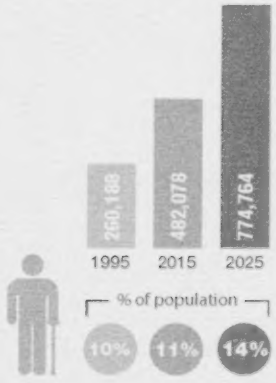
Alberta has urban, rural and remote populations. Certain geographical areas within our province are home to ethnicities, different population structures and unique health needs requiring tailored approaches to health care delivery.

AHS has more than 108,000 employees, including nearly 100,400 direct AHS employees (excluding Covenant Health staff). Over 8,200 staff work in AHS wholly-owned subsidiaries, such as Carewest, CapitalCare Group and Calgary Laboratory Services. We are also supported by more than 15,900 volunteers and more than 9,700 physicians practising in Alberta, more than 7,900 of whom are members of the AHS medical staff (physicians, dentists, podiatrists, oral and maxillofacial surgeons). Students from Alberta's universities and colleges, as well as from educational institutions outside of Alberta, receive clinical education in AHS facilities and community locations.

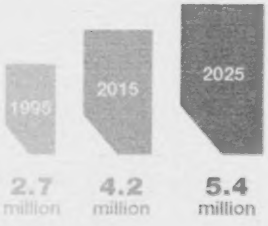
AHS programs and services are offered at more than 650 facilities throughout the province, including hospitals, clinics, continuing care facilities, cancer centres, mental health facilities and community health sites. We also have community-based services designed to help Albertans maintain and/or improve their health status.

All programs and facilities are operated in compliance with specific sections of program legislation.

Aging Population (65+ years)

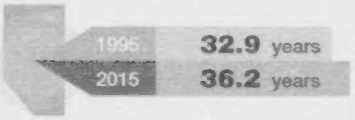


Alberta's Growing Population

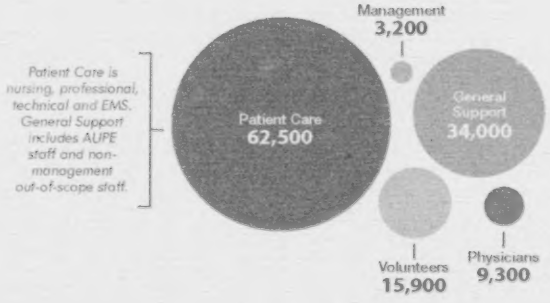


Life Expectancy in Years

Median Age



AHS Workforce


Management 3,200
Patient Care 62,500
General Support 34,000
Volunteers 15,900
Physicians 9,300
Patient Care is nursing, professional, technical and EMS. General Support includes AUPE staff and non-management out-of-scope staff.

Vision, Mission, Values and Foundational Strategies

After talking to our staff, physicians, volunteers and external partners, AHS launched its new vision statement in March 2016. Our vision is what we are striving to attain and what we consider in every decision we make. The AHS vision statement belongs to all Albertans and reflects inclusiveness, community and our shared responsibility for the health and wellness of Albertans. It inspires us and unites us as an organization as we work to provide high-quality health care to Albertans.

The **Vision** of AHS is:
Healthy Albertans. Healthy Communities. Together.

The AHS vision can't stand alone; it must align with our mission and values. Our mission statement communicates our purpose and defines who we will serve and how.

The **Mission** of AHS is:
To provide a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Our **Values** offer a blueprint for decision-making, help attract and retain the best people and describe what we view as important to us as a health care organization. In early 2016-17, AHS re-examined the previous values, listed to the right, to ensure they represent the current organization and reflect the involvement from our workforce, as well as critical external partners. New values will be launched in the coming year. Indeed, we are paying special attention to our front-line teams, who work directly with patients and their families every day, to ensure we capture their perspectives.

Leading with values.

Respect We demonstrate respect for one another, our patients, clients, communities and partners as we lead the evolution of health care.

Accountability We display integrity, act honestly, and evaluate and improve the quality, safety and effectiveness of our services and the outcomes of our decisions. We use best practice to promote excellence, innovation and continuous improvement.

Transparency We value open, honest and timely communication. We disclose information to learn from our mistakes, make available easy-to-understand information about system and financial performance, and clearly lay out our expectations and decision-making processes.

Engagement We collaborate with patients and their families, health care providers, research and education institutions, government and communities, and involve them in meaningful ways in decision-making processes.

Safety We actively promote the safety and wellness of our patients, communities and clients. We can only achieve long-term success if we promote the workplace safety and well-being of our staff, physicians and volunteers.

Learning We seek the best information available and find ways to employ it in our daily work. Learning to be the best also means supporting and promoting the development of new knowledge.

Performance We perform at our highest potential when every person in AHS has a clear and well-understood responsibility to improve their areas of performance every day.

AHS has worked with employees, physicians, volunteers and partners to build four **Foundational Strategies**. These strategies guide our efforts to sustain safe, high-quality health care delivery for the benefit of all Albertans.

Patient First Strategy is designed to strengthen AHS culture and practices to ensure patients and families are at the centre of all health care activities, decisions and teams. There is excellent patient- and family-centred care work underway across the province. AHS continues to spread patient- and family-centred care principles and concepts, shares the work our teams are doing, and provides others with resources and education to do the same.

Our People Strategy is about how we support each other. It is about creating a culture in which we all feel safe, healthy and valued, and can reach our full potential. Through this strategy, workforce engagement will be higher, and patient and family experiences will improve as a result.

Clinical Health Research, Innovation and Analytics Strategy is about how we generate, share and apply evidence critical to providing patient-focused, quality care. Using our Strategic Clinical Networks, AHS works with researchers and innovators to ensure they have timely and secure access to health information, apply and share knowledge, and innovate to achieve service excellence.

Information Management/ Information Technology Strategy will allow health information to flow with the patient so that providers and patients across the province can have access to complete information at the point of care and can learn from the data in the future.

[Volunteers (*n.*)
The roots of strong communities.]

In 2015-16, over 15,900 AHS volunteers gave their time to care for patients. Volunteers touch so many areas of AHS work – in our facilities, at our planning tables and in our communities.

Volunteers are:

- Way-finders who help guide patients and families around our busy facilities.
- Friendly visitors who spend time with our socially isolated patients.
- Patient and family advisors who provide input and direction on numerous committees.
- Researchers with the Strategic Clinical Networks.
- Helpers in health care facility retail gift shops, where proceeds provide care and comfort for our patients.

John Moerman, Senior Chaplain at Chinook Regional Hospital, is thanked by volunteers Annella Wehlage, left, and Lisa Mitchell.

Provincial Quick Facts

The numbers below provide a snapshot of AHS' activity and demonstrate the change in services provided in the past few years.

Alberta Health Services	2012-13	2013-14	2014-15	2015-16	% Change 2014-15 to 2015-16
Primary Care / Population Health					
Number of Unique Home Care Clients	109,184	112,062	114,990	116,462	1.3%
Number of People Placed in Continuing Care	7,761	7,694	7,810	7,879	0.9%
Health Link Calls	755,980	778,353	813,471	755,334	-7.1%
Seasonal Influenza Immunizations	919,348	1,157,550	1,254,950	1,146,569	-8.6%
EMS Events	416,160	461,813	503,769	517,640	2.8%
Food Safety Inspections	94,856	95,389	92,723	92,857	0.1%
Acute Care					
Emergency Department Visits (all sites)	2,116,946	2,142,634	2,181,375	2,134,968	-2.1%
Urgent Care Visits	204,602	205,354	195,312	189,768	-2.8%
Hospital Discharges	385,536	393,765	401,331	404,513	0.8%
Births	51,540	52,323	54,203	55,281	2.0%
Total Hospital Days	2,640,537	2,670,834	2,808,990	2,811,727	0.1%
Average Length of Stay (in days)	6.8	6.8	7.0	7.0	0.0%
Diagnostic / Specific Procedures					
Total Hip Replacements (scheduled and emergency)	5,216	5,243	5,397	5,563	3.1%
Total Knee Replacements (scheduled and emergency)	6,116	6,224	6,377	6,646	4.2%
Cataract Surgery	35,716	36,785	36,583	36,700	0.3%
Main Operating Room Activity	266,469	272,708	275,925	281,312	2.0%
MRI Exams	176,705	190,024	199,928	195,419	-2.3%
CT Exams	344,667	365,181	387,116	391,600	1.2%
X-rays	1,815,841	1,848,122	1,868,044	1,874,879	0.4%
Lab Tests	68,571,727	70,911,298	73,994,032	75,513,093	2.1%
Cancer Care					
Cancer Patient Visits (patients may have multiple visits)	561,625	560,340	578,005	616,237	6.6%
Unique Cancer Patients	50,103	51,105	52,288	55,020	5.2%
Addiction & Mental Health					
Mental Health Hospital Discharges (acute care sites)	19,955	21,008	21,429	22,810	6.4%
Community Treatment Orders Issued	271	359	439	pending	pending
Addiction Residential Treatment & Detoxification Admissions	10,059	9,978	11,180	11,976	7.1%

Note: Health Link volumes — In 2014-15, measles outbreak was the key reason for the difference in call volume as there was no outbreak in 2015-16. Seasonal Influenza Immunization — In 2015-16 there was a later start to influenza illness and influenza activity remained low compared to previous year. Given the economic downturn in Alberta, there were less employers offering onsite influenza immunizations to employees through AHS Workplace Influenza Immunization programs in Edmonton and Calgary. It is important to note the increase in coverage for seniors 65 years of age and older was 62.7% (a 2% increase from last year), one of our more vulnerable populations. MRI volumes — In 2014-15, surplus operating dollars were used to perform additional MRI and CT scans. This was a one-time increase. In 2015-16, AHS maintained budgeted activity numbers and performed the targeted exam numbers.

Bed Numbers

AHS is committed to providing more community-based options for Albertans including long-term care, supportive living, palliative care and home care. A key objective in health care is to shift services from acute care hospital and facility living to the community; bringing care closer to home for patients.

In 2015-16, AHS opened 997 continuing care spaces for a total of 25,135 community-based services. Since April 2010, AHS has opened 5,247 community-based services.

Number of Beds/Spaces as of:	March 31, 2015	March 31, 2016	Difference	% Change
Acute & Sub-acute Care				
Acute Care	8,471	8,478	7	0.1%
Sub-acute in Auxiliary Hospital	507	490	-17	-3.4%
TOTAL ACUTE AND SUB-ACUTE CARE	**8,978**	**8,968**	**-10**	**-0.1%**
Continuing Care				
Auxiliary Hospital	5,521	5,610	89	1.6%
Nursing Home	9,002	9,158	156	1.7%
Long Term Care (LTC) Subtotal	**14,523**	**14,768**	**245**	**1.7%**
Supportive Living Level 4 – Dementia	2,333	2,659	326	14.0%
Supportive Living Level 4	5,342	5,739	397	7.4%
Supportive Living Level 3	1,544	1,538	-6	-0.4%
Supportive Living (SL) Subtotal	**9,219**	**9,936**	**717**	**7.8%**
LONG-TERM CARE & SUPPORTIVE LIVING SUBTOTAL	**23,742**	**24,704**	**962**	**4.1%**
Community Palliative and Hospice (out of hospital)	**208**	**243**	**35**	**16.8%**
TOTAL CONTINUING CARE *(includes LTC, SL and palliative care)*	**23,950**	**24,947**	**997**	**4.2%**
Addiction & Mental Health				
Psychiatric (standalone facilities)	955	955	0	0.0%
Addiction Treatment	883	888	5	0.6%
Community Mental Health	601	625	24	4.0%
TOTAL ADDICTION & MENTAL HEALTH	**2,439**	**2,468**	**29**	**1.2%**
Alberta Total	35,367	36,383	1,016	2.9%

Note: New restorative beds are reported under sub-acute (non-acute care facility) and auxiliary hospital.

Governance

The AHS Board is responsible for the governance of AHS. During the 2015-16 fiscal year, Dr. Carl Amrhein and David Carpenter both served as the Official Administrator of AHS in place of the AHS Board under Section 11 of the *Regional Health Authorities Act*, until the AHS Board was re-introduced on November 27, 2015.

The Board is comprised of seven members with Linda Hughes as the Board Chair. The Board is accountable to the Minister of Health and works in partnership with Alberta Health to ensure all Albertans have access to high-quality health services across the province.

Linda Hughes
(Chair)

Dr. Brenda Hemmelgarn
(Vice-Chair)

David Carpenter

Glenda Yeates

Hugh D. Sommerville

Marliss Taylor

Richard Dicerni

The AHS Board has established the committees specified below to assist in governing AHS and overseeing the management of AHS' business and affairs. The Board Chair is a member of each advisory committee, and the President and Chief Executive Officer is a non-voting ex-officio member of each advisory committee.

- Audit & Risk Committee
- Finance Committee
- Governance Committee
- Quality & Safety Committee
- Human Resources Committee
- Community Engagement Committee

The purpose and scope of each committee is in accordance with good governance practices and is consistent with the governing legislation of AHS.

Organizational Structure

AHS is responsible for delivering health services to more than 4.2 million people living in Alberta.

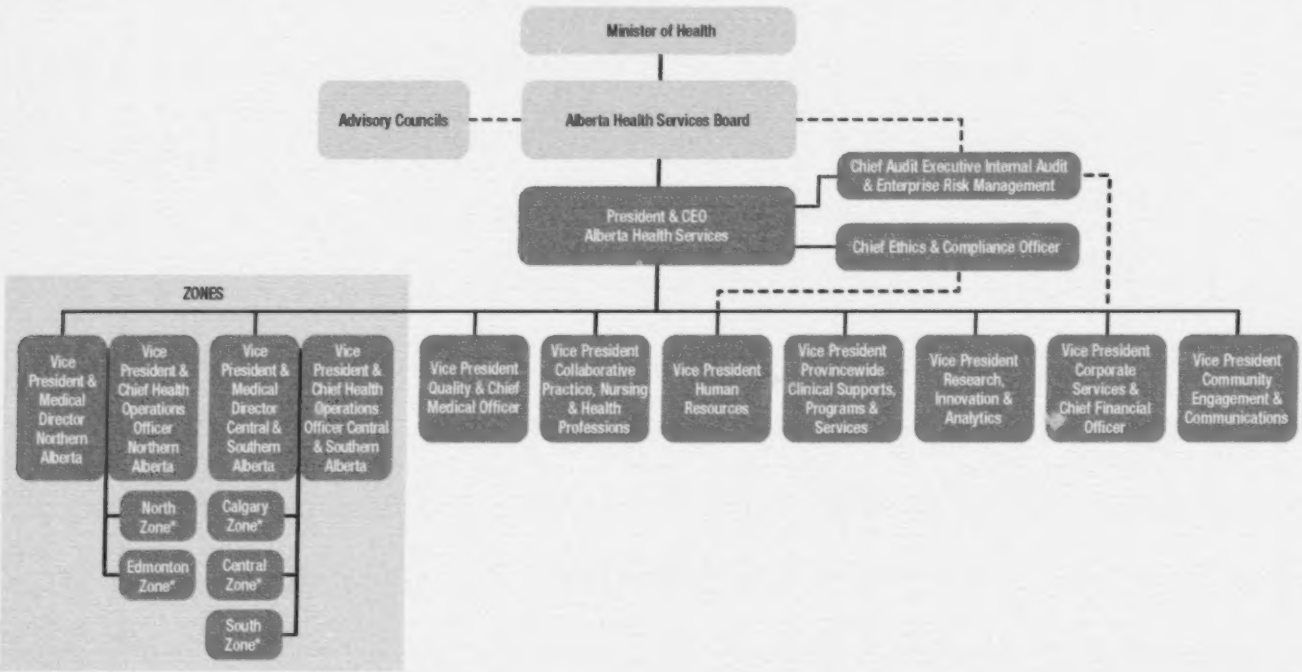
On November 27, 2015, Vickie Kaminski resigned as the President and Chief Executive Officer (CEO) of AHS. On January 11, 2016, Dr. Verna Yiu became Interim President and CEO of AHS. The AHS Board announced Dr. Yiu as the new President and CEO of AHS effective June 3, 2016.

Dr. Yiu leads a staff of over 108,000 caring and dedicated individuals who make up the AHS workforce. In this role, she is leading health services through transformational change, shaping the future for AHS to allow achievement of our strategic directions.

With leaders and staff in the organization, AHS is building a culture that:

- Exemplifies our values of respect, accountability, transparency, engagement, safety, learning and performance.
- Uses the Alberta Quality Matrix of Health as our guide.
- Takes a provincial perspective on issues.
- Ensures good ideas developed in one area of the province are shared across Alberta.

Our organizational structure is arranged under the AHS Executive Leadership Team reporting directly to the President and CEO.

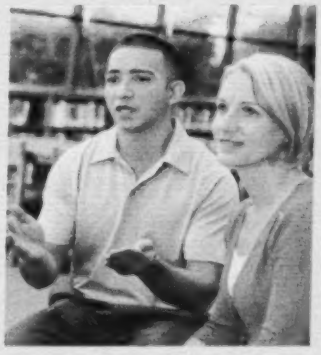

Minister of Health
Advisory Councils
Alberta Health Services Board
Chief Audit Executive Internal Audit & Enterprise Risk Management
President & CEO Alberta Health Services
Chief Ethics & Compliance Officer
ZONES
Vice President & Medical Director Northern Alberta
Vice President & Chief Health Operations Officer Northern Alberta
Vice President & Medical Director Central & Southern Alberta
Vice President & Chief Health Operations Officer Central & Southern Alberta
North Zone*
Edmonton Zone*
Calgary Zone*
Central Zone*
South Zone*
Vice President Quality & Chief Medical Officer
Vice President Collaborative Practice, Nursing & Health Professions
Vice President Human Resources
Vice President Provincewide Clinical Supports, Programs & Services
Vice President Research, Innovation & Analytics
Vice President Corporate Services & Chief Financial Officer
Vice President Community Engagement & Communications

* Denotes Clinical Leader Dyad/Partner Relationship

Councils

Advisory councils help bring the voice of Alberta's communities to health care services. Community input allows us to better address the health care needs of Albertans and brings decision-making to the local level. AHS is committed to engaging the public in a respectful, open and accountable manner to support our strategic directions. AHS has established the following councils to support ongoing collaboration and engagement.

Health Advisory Councils (HACs) engage members of the public in communities throughout Alberta and provide advice and feedback from a local perspective on what is working well in the health care system and where there are areas in need of improvement.



Each of the 12 HACs was established in 2009-10 and represents a different geographical area within the province. The HACs report to the AHS Board Chair.

1. **True North** – *La Crete, High Level & Area*
2. **Peace** – *Peace River, Grande Prairie & Area*
3. **Lesser Slave Lake** – *Slave Lake, High Prairie & Area*
4. **Wood Buffalo** – *Fort McMurray & Area*
5. **Lakeland Communities** – *Lac La Biche, Redwater, Cold Lake & Area*
6. **Tamarack** – *Hinton, Edson, Whitecourt & Area*
7. **Greater Edmonton** – *Edmonton & Area*
8. **Yellowhead East** – *Camrose, Lloydminster & Area*
9. **David Thompson** – *Red Deer & Area*
10. **Prairie Mountain** – *Calgary & Area*
11. **Palliser Triangle** – *Medicine Hat & Area*
12. **Oldman River** – *Lethbridge & Area*

Wisdom Council provides guidance and recommendations to ensure AHS develops and implements culturally appropriate and innovative health service delivery for Aboriginal Peoples. It is comprised of Aboriginal People who volunteer their time on the council. Their backgrounds are wide-ranging, including traditional knowledge-holders (ceremonial leaders), contemporary trained physicians, nursing professionals and health consultants, all equally important when discussing challenges to inform AHS on Aboriginal health and well-being.

Provincial Advisory Council on Addiction and Mental Health advises AHS on programs and services for provincewide addiction and mental health treatment. Its members provide evidence-based suggestions that improve quality of services and patient satisfaction through effective service planning.

Provincial Advisory Council on Cancer advises AHS on services and programs for provincewide cancer care. Its members provide evidence-based suggestions on prevention and screening, diagnosis, treatment and care, and research.

Alberta Clinician Council is an organization-wide forum comprised of front-line clinicians from a variety of disciplines and zones. Applying their collective knowledge, experience and expertise, the council advises senior leadership on issues and opportunities to improve quality, access and patient safety across Alberta.

Patient and Family Advisory Group has been an important avenue for bringing the patient voice into AHS. The group partners with senior leaders to review policy and strategies and share insights from patients' perspectives for the planning and delivery of health care services. Members give their time to numerous committees and projects in AHS, and provide education inside and outside the organization.

2015-16 Health Plan Results

AHS is working continually to improve the quality of care we provide to Albertans. Across the province, significant progress is being made toward building a patient-focused, quality health system that is accessible and sustainable for all Albertans.

As required by Alberta Health, the following section outlines the progress related to the expectations set out in the 2015-2018 AHS Health Plan and Business Plan. Over the past year, we have undertaken many actions which are helping us to advance our three strategic directions. These actions align with the strategic directions and are organized by our 12 strategic objectives.

I. Ensuring Quality of Care in Our Communities

Albertans want more access to the health system so that health care is available when and where they need it. We need to ensure that our health care system is used appropriately and effectively, and we need to shift care to the community where each each Albertan can access it best.

1. Enhance Continuing Care Living Options
2. Provide Better Transitions in Care
3. Improve Hospital Flow Efficiencies
4. Improve Surgical Capacity Management
5. Improve Co-ordination of Emergency Medical Services in Rural and Remote Communities

II. Partnering for Better Health Outcomes

Helping people stay healthy by managing their own health is an essential component of a comprehensive health system. AHS encourages and creates an environment in which people can have enhanced control over their health, the health of their families and the health of their communities. A focus on quality, including patient experience and safety, ensures systems, capacity and tools are used to build the organization's culture and shape its evolution to continuously improve performance and outcomes while also looking for streamlined workflow and cost efficiencies.

6. Improve the Patient Experience
7. Ensure a Quality and Safety Focus in Patient Care
8. Promote and Support Wellness for Our Communities

III. Achieving Health System Sustainability

The successful implementation and continuous improvement of a health system and service requires a variety of supports including: how we use our resources and engage our staff, physicians, patients and communities; how we apply technology and design information systems to support clinical decisions and how we use research; and best practice and models through the work of our Strategic Clinical Networks to improve the quality, outcomes and sustainability of services.

9. Engage Staff, Physicians and Volunteers in a Culture of Patient- and Family-Centred Care
10. Ensure Investment in New Technology and/or Information Management Systems Supports Care Delivery
11. Optimize Service Delivery through Needs-Based Service Planning
12. Integrate Research, Innovation and Analytics in the Delivery of Care

The next section is organized by our three strategic directions. Each strategic direction includes a main feature story followed by 2015-16 results, as well as examples of provincial highlights from this year.

Ensuring Quality of Care in our Communities

Community partner, Edmonton Streetworks Registered Nurse, Mathew Wong, shows the contents of a naloxone kit used to help reverse the effects of opioid overdose.

Taking Action Against Fentanyl Together

Community partners and AHS took action together this year to address the fentanyl crisis in Alberta by expanding access to naloxone, improving addiction treatment and increasing public awareness.

Fentanyl – a powerful opiate 100 times more toxic than morphine, heroin, or oxycodone – caused 272 deaths in 2015.

With funding from Alberta Health, AHS potentially stopped many more deaths through the distribution of the life-saving antidote to fentanyl: naloxone. Since May 2015, Alberta Health and AHS have been making naloxone kits more readily available. Most recently, over 4,000 kits have been distributed to pharmacies and walk-in clinics throughout the province. The Take Home Naloxone Program offers walk-in clinics, and pharmacies across Alberta can prescribe and supply naloxone, a drug that can temporarily reverse a deadly fentanyl overdose and has been proven to save lives.

AHS also rolled-out a fentanyl awareness campaign and related website (www.drugsfool.ca). This sustained effort continues to focus on educating all Albertans about the risk of drugs, how to spot an overdose, and where and why to get naloxone. Since its launch, www.drugsfool.ca has had more than 125,000 visits.

Improving addiction treatment will also help those with opioid dependency, including those who take fentanyl. Across Alberta, nine clinics currently treat opioid dependency issues, providing a full range of counselling and support services. AHS will be further expanding these opioid dependency services.

In addition, AHS will be adding medical detoxification beds for adults, including six to eight new beds in Lethbridge and providing medical support to 20 social detox beds in Red Deer. Three new social detox beds for children and youth will also be opened in Calgary in 2016-17.

2015-16 Ensuring Quality of Care in our Communities

Health Plan Results

1. Enhance Continuing Care Living Options

Offer more continuing care living options for those needing home care, supportive living or long-term care.

- In 2015-16, AHS opened 997 net new continuing care spaces. Since April 2010, AHS has added approximately 5,247 spaces to the continuing care system.
- AHS strives to provide Albertans with care where they want it most: in their homes and in their communities. Almost 116,500 clients with unique needs received home care in 2015-16.
- The Continuing Care Access to a Designated Living Options Policy was approved and provides direction for accessing a Designated Living Option in continuing care for long-term care and supportive living.
- The 2016 Continuing Care Health Service Standards and Information Guide were released by the Minister of Health in January 2016.
- AHS opened 42 restorative care beds which focus on restoring a person's abilities that makes independent living an option and delays/avoids a need for higher levels of care.
- The new Visitation and Family Presence Directive came into effect for all long-term care, designated supportive living settings and contracted partners across the province. This directive reinforces that visitation and family presence is integral to client safety, healing, well-being and quality of life.

Provide caregiver and respite support to enable people to stay in their homes.

- Destination Home projects in Edmonton and Calgary continue to support seniors with complex needs to remain independent at home and to avoid or delay hospitalization and admittance to long-term care.
- A standardized provincial palliative and end-of-life care expert physician-on-call model was developed and implemented.

Provincial Palliative and End-of-Life Care Website

On May 7, 2015, AHS and MyHealth.Alberta.ca launched a new provincial palliative and end-of-life care website. This important new resource provides information to palliative and end-of-life care patients, families and health care providers. There is a search function for services and programs, symptom management tips for patients and families, and content developed specifically for newborns, children and youth.

An up-to-date calendar provides details about upcoming courses, events and conferences related to palliative and end-of-life care, as well as information on new provincial initiatives.

2. Provide Better Transitions in Care

AHS continues to work towards seamless and well-coordinated transitions of care. Focus this year was coordinated through CoACT (page 19) as well as the following.

Support individuals with addictions and mental health conditions and develop interventions for populations with complex needs.

- Dementia Advice through Health Link was launched in North, Central and South Zones in September 2015. The service will be available to Calgary and Edmonton Zones in May 2016. This service provides 24/7 telephone nurse advice for individuals living with dementia and their caregivers.
- Since its inception in August 2013, the Identification for the Homeless Healthcare Project has assisted nearly 1,900 clients to obtain and store identification. The project has been implemented in Calgary, Edmonton, Lethbridge and Medicine Hat with local versions implemented in communities in the South and Central Zones.
- Community Treatment Orders (CTOs) are utilized to support clients who live in the community and reduce time spent in hospital. CTOs were issued for 337 new clients from April 2015 to December 31, 2015, and 887 individuals actively on CTO as of December 31, 2015.
- The Strategic Clinical Networks (SCNs) are working collaboratively on the Appropriate Use of Antipsychotics (AUA) project to guide care for persons living with dementia. The aim is to reduce antipsychotic medication use within long-term care and supportive living facilities and help staff enhance care by focusing on person-centered approaches. The Resident Assessment Instrument (RAI) quality indicator for AUA improved from a baseline of 26.8 per cent Q4 2011-12 to 18.3 per cent in Q3 2015-16. This exceeds the AUA target of 20 per cent expected to be obtained by 2017-18.
- AHS provided training workshops to staff in six high-demand centres on evidence-based practices with the development of alcohol and drug policies in the workplace.
- A collaborative partnership was solidified between the Central Zone and Disability Services Central Region to develop a community support team for people with developmental disabilities.
- South Zone is working with police services to embed mental health and addictions workers within police departments to improve community support to high risk clients.
- Alberta Health, along with AHS Seniors Health SCN, are leading the development of the Alberta Dementia Strategy and Action Plan (ADSAP). The ADSAP will focus on creating a culture within Alberta where individuals living with dementia and their caregivers are accepted, receive the supports and services they require, and realize a high quality of life.

Increase mental health service access for children and youth.

- The Community Helpers Program expanded to three new communities in Calgary, Red Deer and Cochrane. Since its inception in 2011, the program is now in 13 communities across the province. This program provides tools and training to community volunteers to spot signs of mental distress.
- Zones participated in the Regional School Delivery Collaboratives to streamline access to children's addiction and mental health services.
- The Youth Patient Journey study examined homeless youth who transition to homeless adults, including surveying 80 youth across Alberta. Recommendations include examining trends, rural and urban settings, and availability and utilization of resources.
- Calgary Zone completed the Brain Health Integration Plan which highlights future needs for children and youth requiring mental health care and treatment across the health care system.
- Edmonton Zone is increasing access through strategies including parent education sessions and crisis team visits to schools.
- A Suicide Risk Management protocol was developed in the North Zone.

Improve delivery of chronic disease management services.

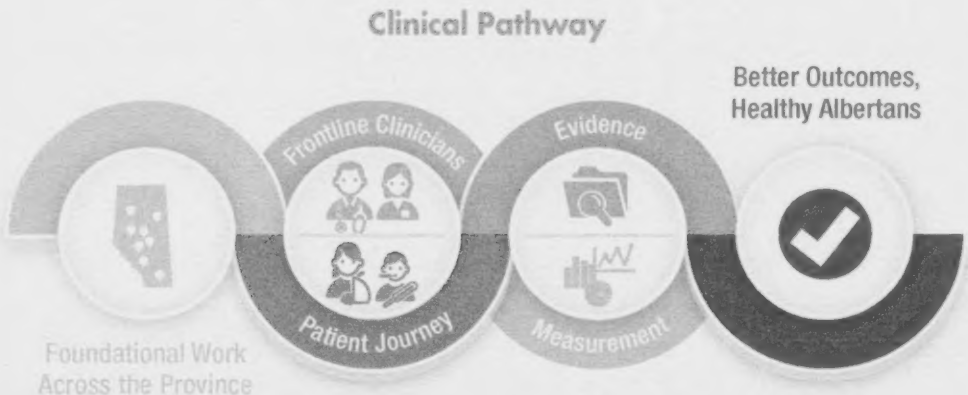
- Led by the Diabetes, Obesity and Nutrition SCN, improved glycemic management care for patients with diabetes in acute care has helped to prevent infections, increase wound healing, decrease length of stay, and avoid readmissions and mortality.
- The Provincial Bariatric Resource Team aims to build knowledge, skills and capacity of health professionals who provide adult and pediatric weight management care. In 2015-16, the team provided 200 consults to health care providers across Alberta.
- Better Choices, Better Health® workshops and education were delivered to over 700 health care providers on chronic disease management, behaviour change, and diversity topics.
- East Calgary Family Care Clinic embedded HealthChange® Methodology into clinical practice. This is a workshop and set of tools for clinicians to support patient-centred care including behaviour change and self-management.

Support rural primary health care capacity and access.

- The Screen Test mobile mammography van reached more than 100 rural and remote communities, providing access to breast cancer screening for women who live in those communities.
- The Rural Facilities Clinical Services Capabilities Framework was revised to align with facility peer grouping and to provide a consistent approach for planning to ensure safe care delivery within rural facilities.
- The Provincial Community and Rural Maternity Care Strategic Plan is under development.
- Enhanced primary care services were developed in the Peace River community and surrounding areas, including the analysis of three key populations: maternal/child health; seniors' health; and addictions and mental health. It is also investigating ways to improve continuity of care.

Develop clinical care pathways through the SCNs to reduce practice variation.

- Clinical care pathways outline a sequence of activities for specific diagnosis groups or patient populations in order to maximize quality of care, efficient use of resources and improve transitions of care.
- The pathways developed in 2015-16 include hip fracture, colorectal cancer, head and neck cancer surgery, community-based diabetic foot care, heart failure, chronic obstructive pulmonary disease, pediatric asthma, depression, pancreatoduodenectomy/hepato-pancreatic-biliary (liver), chronic kidney disease and emergency clinical knowledge.



Improve patient flow in cancer care.

- The number of patients referred to the Alberta Thoracic Oncology Program continues to grow and surgical wait times are showing improvement. In 2015-16, 2,825 referrals were made compared to 2,485 referrals in 2014-15. Surgical wait times from decision-to-treat until surgery improved to 52 days in 2015-16 from 57 days in 2014-15.
- Improvements in staff scheduling and cancellation processes at the Tom Baker Cancer Centre Ambulatory Clinic have helped to decrease patient wait times by 20 per cent.
- Alberta's Tomorrow Project is the province's largest health research study. Launched in 2000, it investigates the causes and prevention of cancer and chronic diseases. Having achieved its recruitment target of 50,000 participants in 2015, it is now promoting its broad database to researchers across Alberta and beyond.
- A new referral-to-consult process for the chemotherapy clinic at the Grande Prairie Cancer Centre (GPCC) was introduced to reduce duplication and standardize roles.
- GPCC implemented the multi-day bloodwork model to support adequate time for safe, efficient preparation, mixing and delivery of chemotherapy for patients.

AHS Research Shows Physical Activity After Diagnosis Helps Men Live Longer

CancerControl Alberta researchers have shown that men with prostate cancer who are physically active survive longer than men who are inactive.

74-year-old Colin Cantlie, who underwent surgery to remove his prostate gland in 2014, says his recovery wouldn't have been as smooth without exercise.

"If I hadn't been physically active after surgery, I think my attitude would have gone downhill and my recovery would have been more difficult. You need to exercise after surgery to help your body recover."

Spanning 17 years and tracking more than 800 patients, the study gives the most comprehensive assessment of physical activity done before and after diagnosis of any study ever conducted.

Dr. Christine Friedenreich, AHS Scientific Leader, Cancer Epidemiology and Prevention Research, and her team assessed lifetime physical activity up to diagnosis, and then did three followup assessments of activity after diagnosis.

The findings show that men who actively participate in recreational activities after diagnosis are at significantly lower risk of dying from prostate cancer, or from any other cause, than are inactive men. Researchers also found that men who are physically active prior to a prostate cancer diagnosis also survive longer.

Dr. Christine Friedenreich with prostate cancer survivor Colin Cantlie.

3. Improve Hospital Flow Efficiencies

Enhance acute care and emergency department flow.

- CoACT is an innovative model of care in which care providers collaborate closely with patients. The following elements were implemented across 20 sites (161 patient care units) in 2015-16:
    - **Collaborative care** is where care providers collaborate more closely with each other, patients and their families to deliver care that is patient-centred and seamless.
    - When health care providers function as a **care hub**, the patient benefits by receiving care from the most appropriate team member.
    - The purpose of **rapid rounds** is to decrease length of stay, identify discharge delays and increase primary care accountability in discharge planning.
    - **Comfort rounds** address patient orientation and safety issues. They also support delirium prevention and management through a collaborative team approach.
    - **Patient bedside whiteboards** provide visual information, keeping patients and their families up-to-date on their care team and plans for the day, including their anticipated date of discharge.
    - **Bedside shift reports** help prevent miscommunication during change-of-shift by moving shift reports to the bedside. There are many benefits, but the most important one is patient safety.
- Consistent public awareness about health care options and alternatives to emergency care can result in reduced wait times. The Know Your Options campaign was promoted across Alberta through a mix of media including television, radio, online, social media, transit, billboards, print and posters for targeted audiences.
- Zones continue to implement flow improvement initiatives like Medworxx and CoACT, and are also engaged in zone-specific projects such as the "Move to Chair" study in South Zone emergency departments (EDs), where patients are moved to a treatment chair once assessments are completed.
- The Emergency SCN and Addiction and Mental Health SCN completed a key recommendation by Choosing Wisely Canada to reduce the use of stat toxicology screening in the EDs in the Calgary Zone. The number of toxicology tests decreased by 96 per cent over a six-month period, meaning patients are no longer subjected to unnecessary testing.
- Calgary Zone implemented a new mental health service stream in three community clinics. This new service stream provides followup care to patients when they are discharged from the emergency department or an inpatient unit, reducing length of inpatient stay and reducing visits to the ED.

4. Improve Surgical Capacity Management

Improve surgical outcomes through implementation of SCN initiatives.

- Enhanced Recovery After Surgery (ERAS) helps patients get back to normal as quickly as possible by providing new and consistent ways of managing care before, during and after surgery. Compliance with the protocol has increased at all sites from 63 per cent in 2014-15 to 73 per cent in 2015-16. ERAS protocol for colorectal surgeries were implemented in six sites in Calgary and Edmonton.
- Adult Coding Access Targets for Surgery (aCATS) helps deliver surgical care in a safe and timely manner. It is a standardized diagnosis-based system to help prioritize surgeries offered throughout the province. aCATS implementation is complete and accounts for 91 per cent of scheduled surgical volume, including non-hospital surgical facilities in the Calgary Zone.
- National Surgery Quality Improvement Project (NSQIP) uses clinical data to measure and improve performance thereby reducing the rate of preventable surgical complications. NSQIP was rolled out at five hospital sites – one in each zone.
- Trauma Quality Improvement Program (TQIP) works to enhance the quality of care for trauma patients. TQIP was rolled out at three Level 1 and 2 trauma sites (Foothills Medical Centre, University of Alberta Hospital and Royal Alexandra Hospital).
- Zones continue to monitor Safe Surgery Checklist compliance.

Manage demand for surgical services.

- Zones continue to work on obstetrical and surgical service plans to better meet the needs of their population.
- As of March 31, 2016, 2,601 breast cancer referrals, 348 lung cancer referrals, and 1,217 hip and knee referrals were sent via eReferral. This is an increase of 3,046 referrals from March 31, 2015.
- The Elder-friendly Approaches to the Surgical Environment (EASE) study was piloted at the University of Alberta Hospital to better support older patients during and after surgery, thereby improving post-operative outcomes.

5. Improve Co-ordination of Emergency Medical Services (EMS) in Rural and Remote Communities

Provide emergency response and inter-facility transfers by ground ambulance, non-ambulance transfer vehicles, and rotary and fixed-wing air ambulance.

- In 2015-16, EMS responded to more than 320,000 emergency calls and over 170,000 patient transfers by ground, and transported 7,000 patients by fixed-wing air ambulance and 1,500 patients via rotary-wing ambulance.
- In 2015-16, investment in lifecycle replacement of EMS vehicles and equipment included 63 equipped ambulances, 18 equipped Paramedic Response Units, and three non-ambulance transport vans.
- Ground ambulance activity has grown on average seven per cent annually since 2009. This increase is reflective of all EMS events including emergency, non-emergency and inter-facility transport.
- AHS collaborated with the City of Red Deer to open a satellite dispatch centre in January 2016.

Implement the EMS Service Delivery Plan.

- The EMS Service Delivery Plan is currently under development. It includes community engagement, available resources and gaps, and specific needs and growth of communities. The final report will be made available in December 2017.

Enhance EMS community programs and improve response for Albertans who live in rural and remote communities.

- The Medical First Responder program continues to enlist rural fire departments to enhance medical first response; there are 100 fire agencies participating in the program.
- EMS provided more than 2,200 automated external defibrillators across the province, with 530 going to rural communities.
- Central Zone began non-ambulance transport services to safely stabilize patients while keeping ambulances available to respond to emergencies. The zone is also supporting a joint initiative to improve end-of-life care and reduce transport of palliative care clients to the emergency department.

EMS Tracks Performance Through New Dashboard

EMS began publicly posting six EMS-specific performance measures in 2015 in the form of a performance dashboard. The measures reflect key areas within EMS that are important measurements of patient safety and care. The measures, updated quarterly, will be used to guide work toward improving the quality, safety and timeliness of ambulance service across the province. Results are available on the EMS webpage.

Partnering for Better Health Outcomes

For first-time mother Carrie Meanley, the advice of a Health Link nurse may have saved her life and the life of her newborn daughter, Anna.

Accessing Trusted Health Advice Now as Easy as 811

Getting trusted health advice around the clock became easier in 2015 with the introduction of the 811 phone number for Health Link, Alberta's free, 24/7 health information and advice line.

The new number replaces the existing 10-digit local numbers in Calgary and Edmonton, as well as the provincewide toll-free number. More than three-quarters of calls to Health Link are now being made using the new 811 number. The old numbers will remain in service to ensure no call is missed.

Health Link is an invaluable service that gives Albertans across the province telephone access to registered nurses and other health professionals. It supported more than one million Albertans last year, often preventing unnecessary trips to the emergency department.

Health Link provides caring and trusted advice, connecting people to the right care from the right provider at the right time and place. It also helps reduce pressures on other areas of the health system. Of those who called with a health concern, nearly half (48 per cent) were given advice to care for themselves at home, 36 per cent were told to visit their doctor or another health care provider, and just 16 per cent were advised to go to the emergency department.

Health Link staff provide advice and navigation services via telephone free of charge, as well as online health information to the public through MyHealth.Alberta.ca.

For one Albertan, Health Link was a life-saver. Carrie Meanley called Health Link when experiencing abdominal pain. After asking a series of questions, the nurse advised the 32-year-old pregnant Calgarian to visit her nearest emergency department. She was diagnosed with HELLP syndrome, a potentially fatal condition.

"I had to have an emergency C-section and it's possible that my daughter Anna or I would not be here today if it weren't for the advice we got from Health Link," says Meanley.

2015-16 Partnering for Better Health Outcomes

Health Plan Results

6. Improve the Patient Experience

Implement the Patient First Strategy to enhance patient-focused care and improve patient satisfaction.

- The Patient First Strategy was rolled out in June 2015 across AHS.
- CoACT collaborative care units have implemented bedside whiteboards, rapid rounds and comfort rounds to enhance patient- and family-centred care.
    - Use of patient bedside whiteboards enables patients and families to be an active part of the care team.
    - Rapid rounds bring together all collaborative care team members to discuss the care plan and what needs to be done that day to move the Integrated Plan of Care forward. They improve patient care quality through efficient, effective, and clear team collaboration.
    - Comfort rounds are patient-focused rounds that are scheduled, purposeful and involve key behaviours that focus on addressing unmet care needs: toileting, mobilization, hydration/nutrition and pain. Rounds are scheduled at least every two hours.
- In alignment with the Patient First Strategy, Accreditation Canada embedded client- and family-centred care content into all clinical service standards and required organizational practices.
- Patient- and Family-Centred Care (PFCC) week was celebrated across Alberta with webinars focused on storytelling.
- The PFCC 101 e-learning module was launched, and over 1,300 AHS staff and physicians took the course (target was 1,200).

7. Ensure a Quality and Safety Focus in Patient Care

Ensure a safe workplace through education, policies and procedures, and continuous improvement.

- MySafetyNet is a new provincial online tool that allows staff to report and manage workplace incidents, hazards, injuries and illnesses. The tool was launched in the South, Calgary and Central Zones. Edmonton and North Zones will go live by summer 2016.
- TeamCARE implements best practices that build strong teams to advocate and care for patients. Work to date has included helping front-line staff handle challenges and improve patient care.
- Continuous improvement in the Workers' Compensation Board program has resulted in an increase in modified work offered from 62.7 per cent in 2014-15 to 69.8 per cent in 2015-16. This played an important role in decreasing total lost work days by four per cent.
- AHS is committed to providing employees with a psychologically safe work environment and access to personal health resources so they can achieve and maintain optimal mental health. AHS has developed and is enhancing the Psychological Safety & Mental Health Strategy to address psychological stressors in the workplace in order to reduce work-related psychological injuries.
- Disabling Injury Rate has improved from 3.69 in 2014-15 to 3.37 in 2015-16. Reducing injury rates is important in ensuring our employees, volunteers and physicians are working in a safe and healthy environment, free from injury.
- Days lost due to occupational injuries are improving – AHS lost 10 per cent less days in 2015-16 compared to 2014-15.

- The Working Alone SafetyLink Mobile App became available to employees working alone in areas with no cellphone service. The app has a distress button to locate the worker and dispatch emergency services if needed.
- The Workplace Hazardous Material Information System 2015 was designed to identify dangers associated with chemicals and other hazardous substances. It incorporates elements of the Globally Harmonized System for the classification and labelling of chemicals.

Improve patient safety and focus on accreditation standards.

- Accreditation Canada's final report showed that AHS met 92.4 per cent of all criteria and 93.5 per cent of its high-priority criteria. A strong commitment to patient safety, the positive impact of SCNs, and a caring and highly competent workforce were strengths noted by the report.
- Over 120 operator continuing care sites have comprehensive emergency disaster planning and basic business continuity planning in place.

Falls Prevention

- The Fracture Liaison Service provides comprehensive followup services for Albertans who have had hip fracture surgery. This service was implemented at the Misericordia Community Hospital, Peter Lougheed Centre and the Red Deer Regional Health Centre. This is a Bone and Joint Health SCN initiative.
- Seniors Health SCN introduced the Elder Friendly Care initiative in acute care which helps to prevents falls, confusion and decreased mobility and function that may happen to older adults in hospital.
- Through the Bone and Joint Health SCN, the Catch a Break Program continues to expand with more screening done for patients at high risk for osteoporosis.

New Albertans Welcomed, Health Supported

From December 2015 to March 2016, Alberta communities welcomed more than 2,700 Syrian refugees, many of whom were experiencing health challenges, including those associated with war and difficult conditions in refugee camps. AHS' collaborative work with community partners and agencies continues to ensure that the complex needs of refugees are met.

From left: Joseph Al-Khoury, Magda Hussein, Dr. Gabriel Fabreau and Bshara Al-Khoury at the Mosaic Refugee Health Clinic in Calgary.

Medication Management

- The Line and Tubing Verification Policy and High Alert Medications guidelines were introduced to avoid errors and improve patient safety.
- Pharmacy Services collaborated with the Diabetes, Obesity, and Nutrition SCN to improve and standardize the care of inpatients with diabetes. The standardization and streamlining of the AHS Provincial Drug Formulary for insulin was completed in the fall of 2015.
- This year, the Pharmacy Good Catch Reporting System became a standardized internal pharmacy tool for voluntary reporting of medication-related events to enhance learning and make improvements in medication distribution processes.

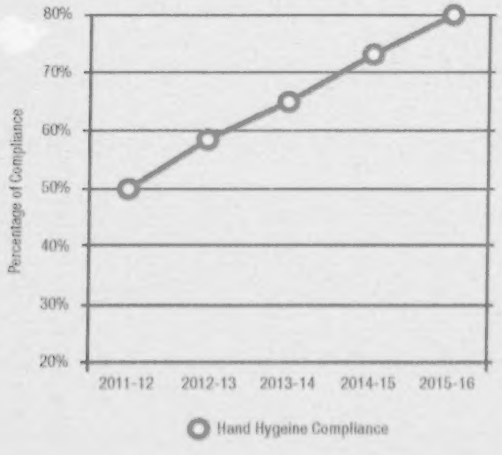
- A provincial policy: "Infusion Pumps for Medication and Parenteral Fluid Administration" is in place to ensure safe and effective use of infusion pumps.
- Zones continue to complete and sustain Medication Reconciliation upon admission, transfer and discharge in acute care, ambulatory care and home care.

Clean Hands. Every patient. Every time.

Hand hygiene is the single most effective way to prevent the spread of communicable diseases and infections. Since 2011-12, hand hygiene rates have improved significantly due to activities put into place at sites.

Good hand hygiene practices are essential in preventing hospital acquired infections, and alcohol-based hand rub is an effective and accessible product. In 2015-16, alcohol-based hand rub guidelines were developed for staff on the prevention and mitigation of harm while supporting standards for acceptable hand hygiene practice.

AHS Infection Prevention and Control also works collaboratively with physicians and staff within our zones to encourage front-line hand hygiene improvement initiatives. In October 2015, more than 7,000 staff and physicians participated in hand hygiene relays provincewide in recognition of the World Health Organization's Global Handwashing Day.



Infection Control Practices

- Revised admission screening guidelines for patients at risk for antibiotic resistant organisms were implemented provincewide.
- A new surveillance protocol was introduced to monitor and report emerging severe acute respiratory illness, such as Middle East Respiratory Syndrome, coronavirus, or pandemic influenza, as well as other communicable diseases transmitted by droplet and airborne routes (e.g., measles).
- Education modules were launched online to support infection control precautions required for persons with Hemorrhagic Viral Disease. This builds upon previous work done during the Ebola outbreak.
- Bugs & Drugs: An Antimicrobial/Infectious Diseases Reference is available on the AHS internal website (Insite) for staff and physicians. This reference is also available via print, iPhone and Android apps. Bugs & Drugs is a collaborative effort between AHS, the Alberta Ministry of Health and the British Columbia Ministry of Health.
- AHS supported over 40 separate antimicrobial stewardship initiatives to improve antibiotic use and launched the "Reduce your Antibiotic Footprint" campaign.

Implement and spread AHS Improvement Way (AIW) initiatives.

- In 2015-16, approximately 114,000 patients were positively impacted (e.g. reduced wait times, preventable harm, costs of unneeded supplies, or overtime) through various AIW initiatives, collaboratives, training and certification.
- Other examples of AIW initiatives include reducing wait times for Stollery Ambulatory Clinics, reducing the number of urgent chemotherapy orders at Grande Prairie Cancer Centre, and decreasing length of stay for neurology and spinal cord patients at multiple sites in the Edmonton Zone.

8. Promote and Support Wellness for Our Communities

Focus on health promotion, wellness and disease and injury prevention.

- Preliminary work was initiated for the Early Hearing Detection and Intervention program across 13 neonatal intensive care units. Infants will be screened for permanent congenital hearing impairment by one month of age. Rollout will continue in 2016 to ensure universal screening and followup care is available for all infants in Alberta.
- The Better Health Better Business campaign, a pilot project coordinated through the Alberta Cancer Prevention Legacy Fund, provides a road map for employees to choose a healthier lifestyle and promote a healthier workplace culture.
- The Tobacco Reduction Program launched the AlbertaQuits Learning Series to provide health professionals with training on tobacco cessation.

AHS Launches First Preconception Health Website

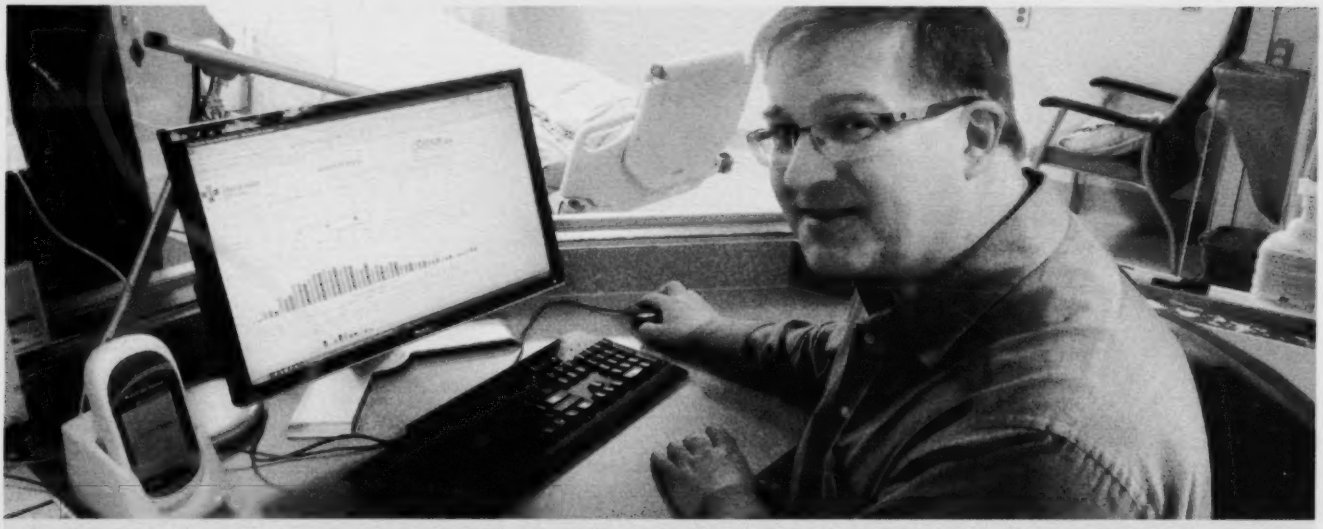
Statistics show 40 per cent of pregnancies are unplanned. This statistic underscores the importance of health before conceiving, whether you're ready for baby or not. Focused on raising awareness and improving preconception health, AHS launched readyornotalberta.ca. With more than 50,400 visits in its first two months, the site is generating interest necessary to improve outcomes.

- Safe Healthy Environments is developing the Healthy Communities by Design initiative aimed at promoting municipal development to support wellness.
- Emergency Disaster Management engaged with Alberta Health and Alberta Emergency Management Agency on the design of a provincial disaster exercise aimed at promoting municipal resiliency.

Increase cancer screening and reduce communicable disease through implementation of preventive measures, reducing risk factors and promoting healthy environments.

- The AHS Sexually Transmitted Infections and Blood Borne Pathogens Five-Year Action Plan 2011-2016 was completed.
- The Aboriginal Health Program implemented youth suicide prevention program initiatives in 20 indigenous communities, provided mental health first aid to three inner city agencies and an indigenous community, and supported flood recovery efforts in Siksika First Nation and Stoney Nation.
- The Enhanced Access to Cancer Screening (EACS) program completed a two-year pilot project in the North Zone to increase access to cervical and colorectal cancer screening in rural and remote communities through the Screen Test mobile unit. Staff delivered 24 EACS clinics, serving nearly 1,600 northern Alberta residents in 67 different communities.
- Work continues in the North Zone with First Nation communities to increase cancer screening as well as to develop standards and training materials for Aboriginal Health staff for education and awareness.

Achieving Health System Sustainability



Dr. Dan Zuege, a critical care physician and the medical director for the eCritical program, demonstrates the eCritical system in the ICU at Peter Lougheed Centre in Calgary. eCritical is now used in all 28 adult, pediatric and cardiac critical care units across the province.

eCritical Enhances Care for Alberta's Sickest Patients

Critical care staff across Alberta now share a powerful computing platform that's helping to enhance care for the most seriously ill patients.

The intensive care unit in Red Deer recently became the final adult intensive care unit (ICU) in the province to roll out eCritical, a provincewide system that allows health care teams to consolidate patient information, analyze data on the fly and streamline patient transfers.

"Beyond enabling excellent bedside care, eCritical also provides us with a wealth of accessible electronic information that supports unit, department and network research and quality initiatives to help identify where we can make improvements," says Dr. Dan Zuege, a critical care physician and the medical director for the eCritical program.

"This system is unique in Canada and is an example of how having one provincial health care system can enable improvements in care to ICU patients across Alberta. This is what AHS was designed to do."

First introduced at the ICU in Rockyview General Hospital in 2012, eCritical is now used by more than 7,000 staff across multiple disciplines in all 28 adult, pediatric and cardiac critical care units across the province.

The bedside component of eCritical, called MetaVision, consolidates information about patients from a variety of sources: clinical documentation from multiple health disciplines; lab and admission systems; and from technologies at the bedside such as ventilators, dialysis machines and monitors that track vital signs.

The system can also generate reminders about specific aspects of patient care, and alert care providers to changes in a patient's condition that require attention.

The other key component of eCritical is a data warehousing system called TRACER which allows for unprecedented provincewide research to drive better care for critical care units in all zones.

The next phase will introduce eCritical to the 13 neonatal intensive care units in Alberta.

2015-16 Achieving Health System Sustainability

Health Plan Results

9. Engage Staff, Physicians and Volunteers in a Culture of Patient- and Family-Centred Care

Complete the development and begin implementation of Our People Strategy.

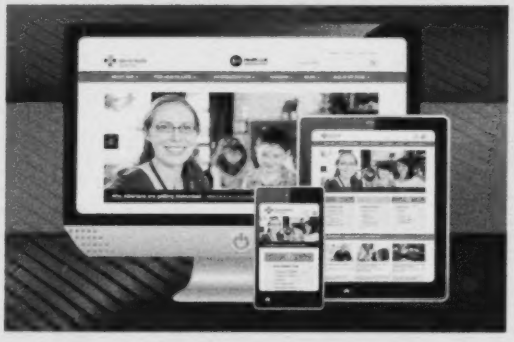
- Our People Strategy, its action plan, and communication and engagement plans were approved by the AHS Board in March 2016. The strategy will be launched in 2016-17.

Create an adaptable and resilient workforce, build leadership capabilities, address rural workforce shortages and effectively engage staff, physicians and volunteers.

- A succession planning tool for managers has been implemented.
- A new cohort for the Executive Education Program began in January 2016.
- Supported by the Emergency SCN, emergency departments have incorporated Emergency Nursing Provincial Education Program modules into their orientation program for new staff.
- The New Manager Preparation Program was piloted in Central Zone. A provincial plan has been developed for full implementation in 2016-17.
- The North Zone Registered Nurse Locum program has been expanded. The use of locums has been well-received and is becoming a viable source of staffing to ensure appropriate, safe and consistent patient care.
- AHS is developing a rural workforce plan that will identify staffing risks and opportunities, and address rural workforce shortages.

A New AHS Website Designed for Albertans

In November 2015, AHS launched a new, more user-friendly external website and a simpler web address. With more than 36 million page views in 2015, the website is often the public's first point of contact with the health system and with an easier-to-navigate design, health information can be found faster. The longer www.albertahealthservices.ca web address has now been replaced with www.ahs.ca.



The new website design places the most important and popular content first, so information can be found with less clicking. Most importantly, the changes to AHS' new online home have taken into account feedback from patients, families, Health Advisory Councils, staff and physicians.

When building the new website, AHS teams also kept in mind that at least one out of three Albertans accesses the website from their mobile devices. So, the new website's responsive design is also specially tailored to be easily readable on mobile devices.

10. Ensure Investment in New Technology and/or Information Management Systems Supports Care Delivery

Development of long-range Information Management and Information Technology (IM/IT) Strategy.

- The IM/IT Strategic Plan was completed in 2014-15. A supporting IM/IT Roadmap is in development for completion in 2016-17.

Advance the Consumer Health Strategy.

- The Alberta Organ and Tissue Donation Registry is for Albertans who want to donate their organs and/or tissues for transplantation after they die. The consumer content and registration tool went live in April 2014. Since then, there has been a steady increase in registrations. As of March 31, 2016, there were over 222,000 registrations completed online. This is a ministry initiative and AHS is collaborating with Alberta Health.
- There were almost four million visits to MyHealth.Alberta.ca in 2015-16, an increase of 65 per cent from the previous year.
- In collaboration with numerous programs and services, 186 new patient care handouts were added to MyHealth.Alberta.ca this year to enhance website content and expand its reach. New content developed includes, for example, "When Your Child's Having a CT Scan" for parents, as well as an 18-page health support for patients about the journey through heart surgery.
- Translations developed in partnership include: a "Healthy Eating: Overcoming Barriers to Change" page in Chinese, Punjabi and Vietnamese; "How to Use a Walker", "How to Use a Cane" and "How to Use Crutches" pages in French and Spanish; and "Cleaning and Sanitizing the Kitchen, Toys and Other surfaces" in Arabic.

Increase the uptake of clinical information systems.

- The number of active AHS users on Alberta Netcare Portal is 40,691, which exceeded the target set by Alberta Health (36,120).
- Phase 1 of the Provincial Health Analytics Network (PHAN) Portal, used to better leverage data, went live August 2015.
- In preparation for a provincial clinical information system, foundational work is underway across the organization, including building a single provider registry of physicians, surgeons and other regulated health care providers and implementing site-wide Wi-Fi services to enable wireless access.
- Significant upgrade and enhancements were done to Meditech for the Rural Clinical Information Systems.
- Eight emergency department knowledge topics (including alcohol withdrawal, chest pain, and deep vein thrombosis) were completed for implementation in clinical information systems.

11. Optimize Service Delivery Through Needs-Based Service Planning

Develop service plans to address capacity issues and align services to population health and community needs.

- Service Profiles (workbooks) were compiled for long-range planning for the Central and Calgary Zones. These workbooks include strategy, initiatives and emerging practices about addiction and mental health, bone and joint health, cancer care, cardiovascular health, child health, critical care, emergency department, emergency medical services, home care, kidney health, medicine, neurosciences and stroke, palliative and end-of-life care, primary care, chronic disease management and population health, rehabilitation, seniors health, surgery, and women's health.
- Five profiles were created for all zones as part of long-range planning work. The profiles present a snapshot of each zone and provide a list of indicators that can be used to describe the zone from a population and service perspective.

- Development of service plans for rural obstetrical and surgical services as well as maternity and child services are at various stages within the zones.
- Work is underway to align master plan recommendations with needs analysis for Royal Alexandra Hospital, Glenrose Rehabilitation Hospital and CapitalCare Norwood campus. Master plans for Misericordia Community Hospital campus and University of Alberta Hospital/Stollery Children's Hospital campus are underway. Master plans for Foothills Medical Centre, Alberta Children's Hospital and Strathmore District Health Services in the Calgary Zone are underway.

12. Integrate Research, Innovation and Analytics in the Delivery of Care

Develop an AHS research strategic plan.

- The AHS Clinical Health Research, Innovation and Analytics Strategy was released in December 2015.

Research highlights can also be found within the Zone Highlights section of this report. Below are additional examples of research and innovation successes.

- A small robot was introduced at the Chinook Regional Hospital in Lethbridge to ease anxiety and reduce pain during procedures for young patients.
- Researchers at Rockyview General Hospital in Calgary are using technology that tracks minute changes in heart rate to predict health outcomes in patients and indicate overall health and wellness.
- Surgeons at the University of Alberta Hospital (UAH) in Edmonton are the first transplant team in North America to use a leading-edge technology that extends the viability of donor livers prior to transplantation.
- The world-leading islet cell transplant team at UAH recently performed its 500th islet cell transplant, which helps people with Type 1 diabetes control their blood glucose levels without daily insulin injections.
- The Northern Lights Regional Health Centre in Fort McMurray launched an elective spine surgery program in December 2014. To date, 24 patients have had a procedure done.

Asthma Research Gives Electronic Care Guide to Family Docs

Nothing puts fear into a parent's heart like watching their child struggle to breathe.

"I've had a few scary moments with Gabriel," says his mother Katherine Carlson, who has asthma herself, just like her two-year-old son. "Every time he gets a cold, he can't breathe – so we end up going to emergency to get it under control."

Children like Gabriel could soon breathe easier thanks to new research that will put a treatment guide into their electronic medical record to ensure they receive the best evidence-based care.

Katherine Carlson holds her two-year old son Gabriel, as Dr. Andrew Cave listens to his breathing.

The Alberta Primary Care Pathway for Childhood Asthma will introduce this innovative mechanism to 22 medical practices across the province as a trial run to assess its benefit in managing childhood asthma in primary care settings. If the results are positive, a full provincial rollout is envisioned.

"What we're attempting to improve is physician and parent management of asthma for their children," says Dr. Andrew Cave, a family physician and University of Alberta professor. "So we developed a template that can be inserted into a patient's electronic records for the doctor; they can click on it when a child with asthma comes through, and follow the path so the patient gets managed ideally."

Dr. David Johnson, Senior Medical Director of the AHS Maternal, Newborn, Child and Youth SCN and a University of Calgary professor, was co-lead with Dr. Cave on the project. Both are members of the AHS Respiratory Health SCN, a provincewide team that helps guide clinical research and care.

Strategic Clinical Networks (SCNs)

AHS has developed networks of people who are passionate and knowledgeable about specific areas of health, challenging them to find new and innovative ways of delivering care that will provide better quality, outcomes and value for every Albertan. SCNs continue to create improvement within focused areas of health care.

The Patient Engagement Reference Group (PERG) supports patient and family advisors and Patient and Community Engagement Researchers (PaCERs). PERG members ensure the patient's voice is heard and incorporated in the SCNs by sitting on committees and contributing to projects with leadership, researchers, health care providers and decision-makers. The group meets quarterly to provide updates, network and learn, promote partnerships between advisors and SCN leaders, and provide a forum for consultation.

Over the last year, SCNs have continued to work on improving the health system. AHS now has 13 SCNs:

- Addiction and Mental Health
- Bone and Joint Health
- Cancer
- Cardiovascular Health and Stroke
- Critical Care
- Diabetes, Obesity and Nutrition
- Emergency
- Kidney Health (new)
- Maternal, Newborn, Child & Youth (MNCY)
- Population, Public and Aboriginal Health (new)
- Respiratory Health
- Seniors Health
- Surgery

Alberta Vascular Risk Reduction Community Pharmacy Project (RxEACH)

Albertans at risk of developing vascular diseases now have improved access to screening and management at their local pharmacies thanks to a new provincewide research program. RxEACH is an equal partnership between the Cardiovascular Health and Stroke SCN, Alberta Health, the University of Alberta and the University of Calgary.

Hyder Mohamed, a pharmacist in Lethbridge participated in the RxEACH study.

RxEACH helps pharmacists identify patients at risk of developing vascular diseases, such as heart attack and stroke. It also helps implement management strategies, such as adapting medications, providing lifestyle or treatment recommendations or sending the patient for blood work. The first study of its kind, RxEACH is part of the Vascular Risk Reduction program – a comprehensive strategy led by the Cardiovascular Health and Stroke SCN.

Ninety per cent of Albertans have at least one risk factor for vascular disease and it is one of the leading causes of death and disability in North America. However, many are not aware they are at risk. RxEACH has helped reduce participating patients' risk for a vascular event by 21 per cent. Pharmacists at 56 pharmacy sites across Alberta have enrolled more than 720 patients who have vascular risks such as diabetes, established vascular disease, chronic kidney disease and who have high blood pressure, high cholesterol, high blood sugar or who smoke.

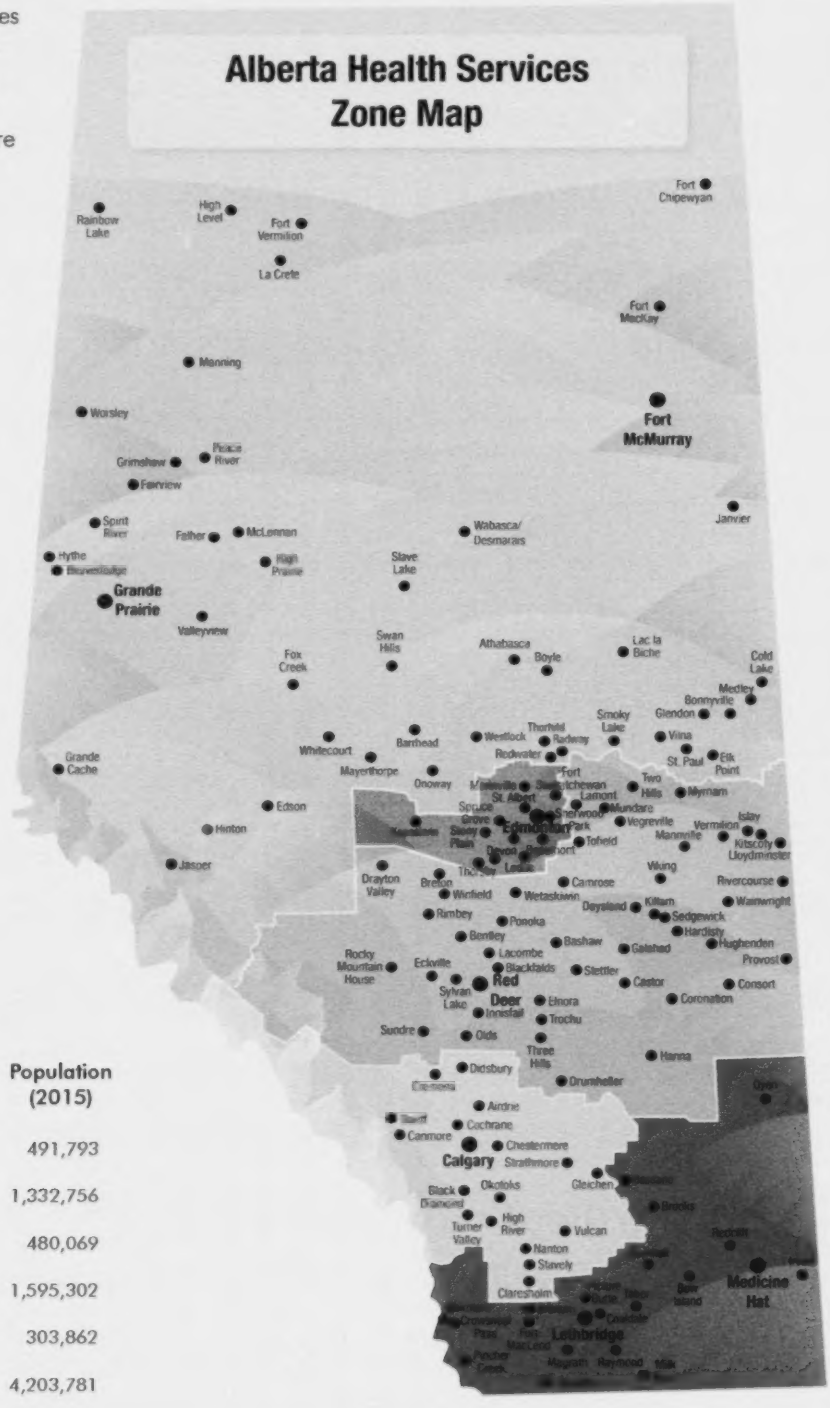
AHS Map and Zone Highlights

AHS is organized into five geographic zones – South, Calgary, Central, Edmonton and North – so communities are more directly connected to their health services, and decisions can be made closer to where care is provided.

Our zones are invaluable in terms of providing decision-making at a local level, and listening to and responding to local communities, local staff members, and patients and clients. Provincewide services, such as emergency medical services; population, public and aboriginal health; diagnostic imaging; quality and safety, work in cooperation with the zones to deliver care.

The next section includes a high-level overview of each zone as well as examples of some of the great work done this year.

Zone Quick Facts and detailed information about beds and facilities are provided in the Appendix.



South Zone Highlights

Bhutanese refugees who have found a new life in Lethbridge attend a meeting put on by the Newcomer Health Group, a group facilitated by AHS.

New Home, New Hope: Newcomers Welcomed

Bhutanese refugees who escaped persecution and fled half a world away are getting the health care they need in Lethbridge thanks to the Newcomer Health Group.

The group – a partnership between physicians, health providers, Lethbridge Family Services and the local Himalayan South Asian community – is teaching these newcomers about nutrition, chronic disease prevention and management, and other health issues.

"We're creating a health network for newcomers, a one-stop-shop where they can access whatever health resources they may need," says Stasha Donahue, AHS Diversity and Self-Management co-ordinator and group facilitator. "Not all issues are health issues, but housing, employment and education can greatly affect a person's health."

Family physician Dr. Eric Bly joined the group to better support his patients, many of whom are Bhutanese.

"Some of the newcomers might not have seen a doctor in 20 years," says Dr. Bly. "Minor eye injuries or ear infections that could have been easily treated have turned into blindness or hearing loss."

As a result,, the Newcomer Health Group is customizing education resources to aid people in getting the care they need, when they need it, in a way they can understand. For example, Canada's Food Guide has been translated into Nepali and adapted to better reflect the Bhutanese diet. Medication labels and other resources are being translated and will incorporate more visual cues and pictures.

"This Newcomer Health Group will help people like us, who have limited English and are eager to learn about our health and how to live healthy," says Nar Maya Darji, 69, through an interpreter. "It is very nice to have something written in our own language."

South Zone Overview

Population Statistics

Overall population: **303,862**

Aging Population (over 65 years): **43,782**

Life Expectancy: **80.9** years

Median Age: **36.4** years

Facts at Your Fingertips

29% are obese

14% smoke daily

51% are active or moderately active

39% eat five or more servings of fruit/vegetables daily

17% are heavy drinkers
(≥ five drinks on one occasion, at least once a month)

Source: Canadian Community Health Survey 2014

Land Mass: 65,500 km²

A Sampling of South Zone Highlights from 2015-16

Dr. Lena Derie-Gillespie joined the public health team as the third Medical Officer of Health. Physicians were recruited for Oyen, Milk River and Bassano. Other specialties recruited include pediatrics, pathology, psychiatry, geriatrics, surgery, urology, orthopedics and oncology.

- A new 84-bed supportive living facility, Meadow Ridge, opened in Medicine Hat and added much-needed continuing care capacity to the community.
- Milk River physician Dr. Liesl Lewke-Bogle won the Rural Physician Action Plan award.
- Chinook Regional Hospital redevelopment project nears completion as the first departments moved into the new wing and the new emergency department entrance opened.
- Lethbridge surgeon Dr. Carrie Kollias performed a leg-lengthening procedure – the first in Canada using the Precice Nail implant – on motorcycle racer Royce McLean.
- One-stop health service centres were created in Taber and Raymond as the health centres in those communities saw integration of primary care, community programs and acute care.
- The 18-bed Medicine Hat Recovery Centre officially opened with a combination of medical detoxification and residential addictions treatment.

Calgary Zone Highlights

Five-year-old patient Micah McKay benefits from a new pain management program at Alberta Children's Hospital during a recent visit to the emergency department. Flanking her are her mom Lindsay McKay, left, and Dr. Antonia Stang.

Putting Pain in its Place

After five-year-old Micah McKay fractured her wrist skating, it was difficult for her to describe her pain.

"For her to see a picture and relate her emotion to the face she sees is way easier than her trying to describe what she's feeling, especially around people she doesn't know," says mom Lindsay McKay.

Developed by an AHS team of doctors, nurses and child life specialists and launched last fall – the Commitment to Comfort program aims to add to a child's comfort and reduce their pain in the emergency department (ED).

"Treating pain is a top priority, and it's also important to the patients and families we see," says Dr. Jennifer Thull-Freedman, ACH ED physician.

"This works to educate families on options available to them and provide pain-management to every ED patient."

Work on the project began two years ago when two ED physicians looked into what to do to better manage pain.

In talking to ED patients with painful injuries, approximately 15 per cent said they would have taken pain medicine but it wasn't offered, while 18 per cent said they felt their pain was not managed effectively.

To promote the campaign, pain-management options are displayed in the ED. Patients are also given a bookmark-sized pain scale to help them describe their pain and help staff understand their pain levels.

Feedback shows the program is effective.

"We've collected feedback from over 500 patients and families," says ED physician Dr. Antonia Stang. "Five per cent now say they wanted pain medicine but didn't receive it, and families dissatisfied with pain care have decreased from 15 to five per cent. We're working toward having 100 per cent of our patients satisfied with pain management."

The program will expand to Peter Lougheed Centre, South Health Campus, and Rockyview General Hospital by early summer.

Calgary Zone Overview

Population Statistics

Overall population: **1,595,302**
Aging Population (over 65 years): **169,856**
Life Expectancy: **83.5** years
Median Age: **36.5** years

Facts at Your Fingertips

20% are obese
12% smoke daily
61% are active or moderately active
44% eat five or more servings of fruit/vegetables daily
20% are heavy drinkers (≥ five drinks on one occasion, at least once a month)

Source: Canadian Community Health Survey 2014

Land Mass: 39,300 km²

A Sampling of Calgary Zone Highlights from 2015-16

Dr. Brian Cornelson, Medical Director of the East Calgary Family Care Clinic, discusses a patient case with registered nurses Carrie Sauve and Analicia Bozzo.

- The Peter Lougheed Centre in Calgary has collaborated with the Mosaic Primary Care Network and the East Calgary Family Care Clinic to improve patient experience and health status while delivering fiscally-responsible care to patients with complex high needs.
- A new resuscitation device, INSPIRE, was introduced at the Foothills Medical Centre neonatal intensive care unit to help preterm babies get crucial medical interventions while connected to their umbilical cords.
- Patients with vascular conditions have access to more comprehensive treatment with the opening of the first phase of the redeveloped Vascular Centre of Excellence at the Peter Lougheed Centre.
- A collaborative project with primary care has led to innovations that help improve care for patients with gastrointestinal conditions. Initiatives include the implementation of a specialist link phone line and delivery of education for self-management.
- The No One Dies Alone initiative provides 24/7 on-call compassionate volunteers to patients who are dying and have no support or whose support requires respite.
- The Hospital at Home is a pilot program at the Alberta Children's Hospital where registered nurses administer chemotherapy and provide education to parents and families in the comfort of the family's own home.

Central Zone Highlights

Janice Kutney, an AHS children's mental health therapist, left, partners with teacher Julie Hodder in a Journeys classroom to help youth with mental health and behavioural issues.

Program Eases Students' Journeys

In the three years since the first students entered its classroom, an alternative school program in Red Deer is making a difference for youth with complex mental health and behavioural needs.

The Journeys Learning Program supports students between the ages of 11 and 18 who have exhausted all the options available through traditional schools in their own communities.

In this collaborative effort between AHS and five school divisions, health professionals and teachers work with Central Alberta Child and Family Services and the Red Deer RCMP to ensure students struggling with mental health issues have their needs met.

For Marsie Tyson of Rocky Mountain House, Journeys is just what her family needed. Tyson's son struggled in school from the age of seven after a diagnosis of ADHD. Now in Grade 10, her son is thriving at Journeys.

"His educators have been able to teach him to manage his own symptoms, teach him real-life strategies and to become his own advocate. For the first time in eight years he feels he has a voice," says Tyson.

"At Journeys, my child feels safe, respected and encouraged."

Social worker and children's mental health therapist Janice Kutney spent years working in children's mental health at AHS before taking on her current role at Journeys. According to Kutney, the Journeys classroom works because it's about adapting the environment to meet the needs of the kids.

"It's wonderful to be a part of these kids' lives," says Kutney, who helps the students develop the skills they'll need to eventually transition back to their home schools.

"The kids never leave here at the end of the day without every incident being processed, each relationship repaired."

In 2014, Journeys received the Premier's Award for School Board Innovation and Excellence.

Central Zone Overview

Population Statistics

Overall population: **480,069**

Aging Population (over 65 years): **67,180**

Life Expectancy: **79.9** years

Median Age: **37.3** years

Land Mass: 95,000 km²

Facts at Your Fingertips

27% are obese

18% smoke daily

57% are active or moderately active

39% eat five or more servings of fruit/vegetables daily

19% are heavy drinkers (≥ five drinks on one occasion, at least once a month)

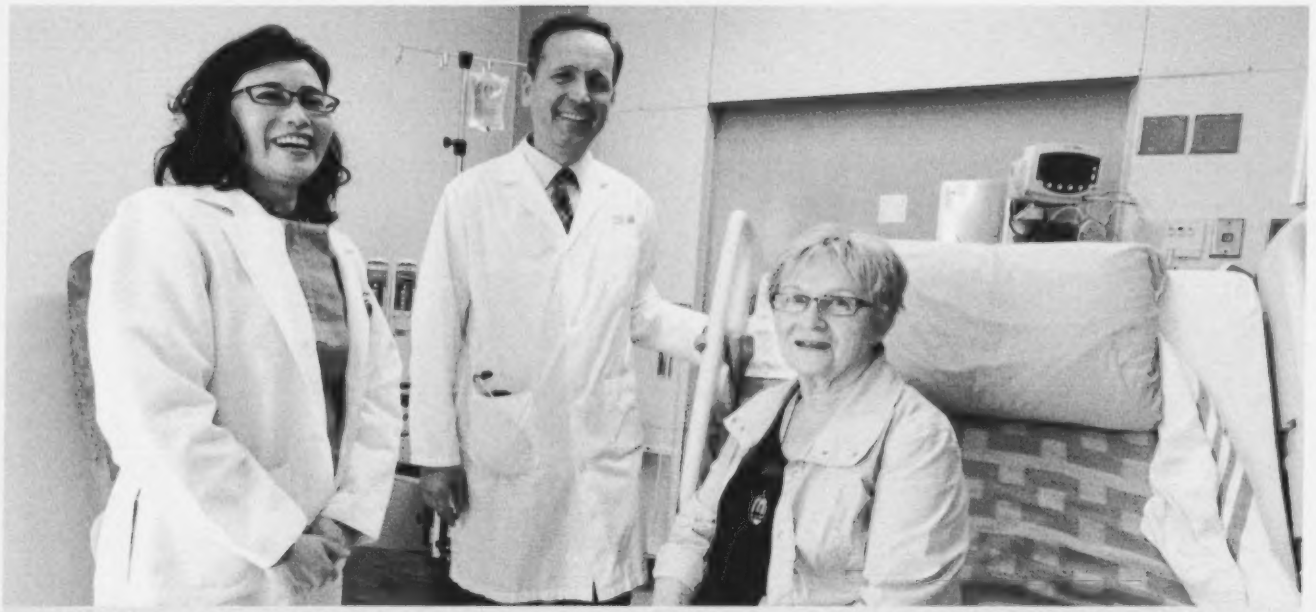
Source: Canadian Community Health Survey 2014

A Sampling of Central Zone Highlights from 2015-16

When the dialysis unit at the Wetaskiwin Hospital and Care Centre began offering evening appointments, it was music to the ears of patient Teresa Parks. Literally. As one of the first dialysis patients to sign up, Parks was serenaded by members of the New Measure Orchestra, who played for patients undergoing treatment as the facility celebrated its new extended hours.

- The Central Alberta Cancer Rehabilitation program is the first of its kind to be launched in the province's regional cancer centres.
- Carpal tunnel surgery, breast reductions/ augmentations and tendon repairs can now be performed at the Innisfail Health Centre with the addition of a plastic surgery program.
- Real-time estimated emergency department wait times for Red Deer Regional Hospital Centre are now available online, giving central Albertans another tool to help them decide where to access care for themselves and their families.
- New non-ambulance transport vehicles were added to help keep emergency medical services ambulances available for urgent and emergency responses.
- A new two-room palliative care suite and a family room were a welcome addition at the Wetaskiwin Hospital and Care Centre to provide quiet comfort, privacy and socialization for palliative patients and families.
- A Red Deer Regional Hospital Centre multi-disciplinary team revamped cardiac information into more streamlined, simple content for patients and families.

Edmonton Zone Highlights



Surgeon-scientist Dr. Rachel Khadaroo and geriatrician Dr. Darryl Rolfson join 70-year-old patient Susan Gokiert, a participant in the EASE research study.

'Elder-friendly' Surgical Unit Gets Seniors Home Sooner

Getting elderly patients home sooner, stronger and with fewer complications after emergency general surgery is the goal of an 'elder-friendly' emergency surgical unit at the University of Alberta Hospital.

It's all part of a clinical research study called EASE – Elder-Friendly Approaches to the Surgical Environment – a collaboration between AHS and the Faculty of Medicine & Dentistry at the University of Alberta, led by Dr. Rachel Khadaroo, a surgeon-scientist, critical care specialist and assistant professor in the department of surgery.

"We're one of the first to transform a surgical unit into an elder-friendly environment," she says. "We're looking beyond the operating table for answers to better care. We're testing new ways of doing pre-operative and post-operative care, ideally to reduce the length of stay in hospital as well as complications such as falls and delirium, which are so detrimental to well-being."

With Alberta's elderly population predicted to reach 20 per cent by 2030, a better understanding of their special needs with regards to emergency surgery is needed, adds Dr. Khadaroo.

Being bedridden in hospital can lead to mental and physical decline – up to five per cent of muscle mass is lost daily.

The University of Alberta Hospital clinical trial is being funded through The Partnership for Research and Innovation in the Health System, a joint venture between Alberta Innovates – Health Solutions and AHS that aims to improve health outcomes for patients across Alberta. Earlier seed funding came from the M.S.I. Foundation and the University Hospital Foundation. Researchers working on this project are also affiliated with the Seniors' Health Strategic Clinical Network.

Edmonton Zone Overview

Population Statistics

Overall population: **1,332,756**
Aging Population (over 65 years): **156,340**
Life Expectancy: **82.1** years
Median Age: **36.2** years

Land Mass: 11,800 km²

Facts at Your Fingertips

21% are obese
15% smoke daily
55% are active or moderately active
35% eat five or more servings of fruit/vegetables daily
18% are heavy drinkers (≥ five drinks on one occasion, at least once a month)

Source: Canadian Community Health Survey 2014

A Sampling of Edmonton Zone Highlights from 2015-16

Teens with chronic pain can earn three school course credits through Chronic Pain 35 classes at the Stollery Children's Hospital. Students with chronic pain often struggle to accumulate sufficient high school credits to graduate with their classmates, and require summer school or online courses to get the bare minimum credits for a diploma. Emma Snow (left) and Bailey Voltner (right) celebrate getting their credits.

- Staff at the Royal Alexandra Hospital set a new Guinness World Record for the most people consecutively cleaning their hands.
- Camrose children with developmental disabilities and their families now have access to experts based in Edmonton to aid in diagnosis and treatment in their own community using Telehealth videoconferencing technology. This project saves time, travel and expense for patients and families, reduces delays and the number of appointments it takes to assess children and to decide on their future care.
- Canada's first stroke ambulance was created. It contains a CT scanner and clot-busting drugs to help potentially cure a stroke before the patient reaches hospital.
- A new 22-bed hospice and long-term care unit opened in the community of St. Albert.
- New surgical nurses are receiving more hands-on simulation training at the Centre for the Advancement of Minimally Invasive Surgery, based at the Royal Alexandra Hospital. This will better prepare nurses for the operating room, and optimize patient safety and outcomes.
- A new emergency medical services station opened in Parkland County – to serve growing communities west of Edmonton.

North Zone Highlights

Members of the Northwest Health Foundation, from left, Mike Osborn, Helen Brown, Sandi Mann, Carla Komarnicki and Leone Whitfield flank Dr. Peter Miles, centre, a visiting physician from Grande Prairie, in front of new equipment for the High Level endoscopy clinic.

New High Level Endoscopy Clinic Brings Care Close to Home

Residents in northwestern Alberta have increased access to specialty care thanks to AHS, the Northwest Primary Care Clinic, the Northwest Health Foundation and area physicians.

Since May 2015, physicians from Grande Prairie have been travelling to High Level every four weeks or so to offer a two-day endoscopy clinic at the hospital, providing gastroscopies and endoscopies used to diagnose gastrointestinal illnesses and screen for cancer.

Dean Schofield, from Rainbow Lake, is thankful for the new service. A gastroscopy test was needed to help determine what was making the 20-year-old sick. Prior to endoscopy being available in High Level, he would have had to travel five to six hours to Grande Prairie or McLennan.

"I can't really work because of being so sick. I don't really have the money to make that trip. My dad would have to travel with me because you can't drive after the procedure, so he would've had to take time off work too," says Schofield.

Having the procedure in High Level will make a huge difference to Schofield and others, with plenty of positive feedback from the community since the clinic opened.

"It's one of the best things that's happened in the five years I've been here," says Dr. Heinrich Brussow, Community Medical Director and Associate Zone Medical Director. "It will reduce wait times and save a lot of patients days travelling."

AHS received funding for new endoscopy equipment from a provincial replacement grant and hospital staff were trained to provide the new service.

"Up to 60 patients from our area were making the trip to get endoscopies each month," says Angie Mann, an area director with AHS. "There is a large support team who come together to make each clinic a success."

The Northwest Health Foundation also helped purchase an endoscope flushing pump for the clinic, while the Northwest Primary Care Clinic provides funding towards the cost of bringing specialist physicians to the community for the clinics.

North Zone Overview

Population Statistics

Overall population: **491,793**

Aging Population (over 65 years): **44,920**

Life Expectancy: **79.2** years

Median Age: **33.9** years

Facts at Your Fingertips

31% are obese

21% smoke daily

54% are active or moderately active

31% eat five or more servings of fruit/vegetables daily

21% are heavy drinkers (≥ five drinks on one occasion, at least once a month)

Source: Canadian Community Health Survey 2014

Land Mass: 448,500 km²

A Sampling of North Zone Highlights from 2015-16

Dr. Vincent Agyapong, an adult psychiatrist in Fort McMurray and Associate Clinical Professor with the Department of Psychiatry at the University of Alberta, has launched the Text4Mood program across northern Alberta in partnership with AHS Addiction and Mental Health.

- A wider range of services is now available at the Slave Lake Family Care Clinic after moving into a larger, newly renovated space at the Slave Lake Healthcare Centre.
- A pilot program in continuing care facilities teaches staff and residents oral health care techniques to promote healthier mouths as well as identify emerging oral health issues.
- Working in partnership with the NorthernStar Mothers Milk Bank, the Grande Prairie Milk Drop opened at the public health centre, offering donor milk to babies.
- Total contact cast therapy is now a treatment option at the outpatient clinic at the Queen Elizabeth II Hospital for patients with diabetes. The therapy helps to heal foot ulcers, which sometimes leads to complications.
- A new program offered on the long-term care unit at Northern Lights Regional Health Centre (NLRHC) offers residents the chance to interact with moms and babies through music.
- Repairs and upgrades were completed at NLRHC including a new fire suppression system and replacement of older pipes. This investment is important to help extend the use of the facility.

Performance Results

Performance Measures ■

Monitoring Measures ■

Performance Measures

AHS' 17 performance measures were established in collaboration with Alberta Health. The measures reflect a balance across the spectrum of health care and accurately reflect health system performance. They were developed to enable us to compare AHS performance nationally. The measures play a key role in advising staff and physicians about our progress and where we may need to adjust actions to achieve the identified targets; they also help in communicating with Albertans about the value provided by health funding expenditures.

The performance measures are organized according to the Alberta Quality Matrix for Health, developed by the Health Quality Council of Alberta (HQCA), which describes six dimensions of quality: acceptability, accessibility, appropriateness, effectiveness, efficiency and safety.

The 2015-16 targets were established in the AHS 2014-17 Health Plan and Business Plan. These performance targets help us measure our progress and improve the health system.

Summary Results

AHS remains committed to building on its performance through quality improvement and innovation, and to strive toward the goal of delivering the type of health care system expected by Albertans. When we look at 2015-16, we can see improvements in a number of areas when comparing performance last year.

AHS continues to see volume increases (Refer to Provincial Quick Facts page 7). The demand for services continues to increase within the province as shown within the volume tables beside each measure. Initiatives within AHS are being put in place in an effort to not only move measures towards their targets, but also to compensate for these increases in demand.

Two measures: Early Detection of Cancer (Alberta Cancer Registry Data), and Satisfaction with Long-Term Care (HQCA) are reported by external sources and their reporting cycles, which are not annual, do not align with AHS'.

The chart on the following page demonstrates trending of AHS' 15 system performance measures for 2015-16 (excludes the two measures noted above). Further analysis and explanation of variances can be found in the Q4 2015-16 performance measure report — available on the AHS website.

- Five measures have achieved 2015-16 targets.
- Eight measures are at or better than last year's performance.
- Five measures reflect the third quarter year-to-date data (April 1, 2015 to December 31, 2015) These measures rely on patient followup after the patient's discharge for a period up to 90 days. Therefore, results reflect the most current data available.

Three out of 15 performance measures have not demonstrated improvement or achieved target from last year. AHS continues to perform well nationally for two of these measures.

- **Percent of children offered scheduled mental health** treatment within 30 days from referral deteriorated from 89% in 2014-15 to 85% in 2015-16. AHS continues to work with other government ministries to streamline access to children's addiction mental health services.
- **Stroke mortality** has also deteriorated from 13.9% (2014-15) to 14.8% (Q3 2015-16). AHS continues to work with the Strategic Clinical Networks (SCNs) to implement the Stroke Action Plan. Alberta ranked fourth best nationally (out of 10 provinces).

- **Surgical readmissions** have shifted slightly from 6.5% compared to 6.6% (Q3) during the same period as last year. SCNs continue to work on various initiatives to improve outcomes for patients after surgery, such as the National Surgical Quality Improvement Program/Trauma Quality Improvement Program (NSQIP/TQIP), Adult Coding Access Targets for Surgery (aCATS) and Enhanced Recovery After Surgery (ERAS).

The trend column indicates comparison of the most recent available data over the earliest data available for each measure. A check (✔) indicates the 2015-16 target was achieved; an upward arrow (↑) indicates improvement; a horizontal arrow (→) indicates stability and a downward arrow (↓) indicates areas that require additional focus.

Performance Measure	2011-12	2012-13	2013-14	2014-15	2015-16	Year-to-Year Comparison	Target 2015-16	National Comparison
Acceptability: Health services are respectful and responsive to user needs, preferences and expectations.								
Satisfaction with Hospital Care: The percentage of adult patients who rated their overall care in hospital as 8, 9 or 10, where zero is the lowest level of satisfaction possible and 10 is the best.	84%	81%	82%	82%	82% Q3 YTD	→	84%	Not available
Satisfaction with Long-Term Care: The percentage of families of long-term care residents who rated the overall care as 8, 9 or 10, where zero is the lowest level of satisfaction possible and 10 is the best.	Reported by Health Quality of Council of Alberta in 2007 as 71% and in 2010 as 73%.			72%	Reported every 3 years by HQCA.	Not available	78%	Not available
Safety: Mitigate risks to avoid unintended or harmful results.								
Hospital-Acquired Clostridium difficile Infections: The number of Clostridium difficile infections (C-diff) acquired in hospital every 10,000 days of care. A rate of 4.0 means approximately 100 patients per month acquire C-diff infections in Alberta.	4.2	4.1	4.4	3.5	3.6 Q3 YTD	✔	4.0	Alberta ranked better than national results
Hand Hygiene: The percentage of times health care workers clean their hands during the course of patient care.	50%	59%	66%	73%	80%	✔	80%	Not available
Hospital Mortality: The actual number of deaths compared to the expected number of deaths in hospital. Values less than 100 mean fewer than expected deaths in Alberta.	88	84	84	82	82	✔	84	Alberta ranked 3rd best nationally (out of 10 provinces)
Accessibility: Health services are obtained in the most suitable setting in a reasonable time and distance.								
Emergency Department (ED) Wait to see a Physician: The average patient's length of time in emergency department before being seen by a physician at the busiest emergency departments.	1.4 hours	1.3 hours	1.3 hours	1.4 hours	1.3 hours	↑	1.2 hours	Alberta ranked 4th best nationally (out of 5 provinces)
ED Length of Stay for Admitted Patients: The average patient's length of time in the ED before being admitted to a hospital bed at the busiest EDs.	8.8 hours	8.7 hours	8.6 hours	9.9 hours	9.4 hours	↑	8.2 hours	Alberta ranked 3rd best nationally (out of 5 provinces)

Performance Measure	2011-12	2012-13	2013-14	2014-15	2015-16	Year-to-Year Comparison	Target 2015-16	National Comparison
ED Length of Stay for Discharged Patients: The average patient's length of time in the ED before being discharged at the busiest EDs.	3.1 hours	3.1 hours	3.0 hours	3.2 hours	3.2 hours	→	2.8 hours	Alberta ranked 4th best nationally (out of 5 provinces)
Access to Radiation Therapy: The length of time or less that 9 out of 10 patients wait to receive radiation therapy.	3.1 weeks	3.0 weeks	3.0 weeks	3.1 weeks	2.9 weeks	↑	2.6 weeks	Alberta ranked 3rd best nationally (out of 9 provinces)
Children's Mental Health Access: Percent of children (age 0-17 years) offered scheduled community mental health treatment within 30 days from referral.	n/a	n/a	87%	89%	85%	↓	90%	Not available
Appropriateness: Health services are relevant to user needs and are based on accepted or evidence-based practice.								
Continuing Care Placement: The percentage of people placed into continuing care within 30 days of being referred.	64%	67%	69%	60%	60%	→	70%	Not available
Efficiency: Resources are optimally used in achieving desired outcomes.								
Acute (Actual) Length of Hospital Stay Compared to Expected Stay: The actual length of stay in hospital compared to the expected length of stay in hospital. Every .01 drop in this ratio means we can treat over 3,200 more patients in hospital every year.	1.01	0.98	0.97	0.96	0.93	✔	0.96	Alberta ranked 3rd best nationally (out of 9 provinces)
Effectiveness: Health services are based on scientific knowledge to achieve desired outcomes.								
Early Detection of Cancer: The percentage of patients with breast, cervical and colorectal cancers who are diagnosed at early stages.	66% (2011) 67% (2012) 68% (2013) 69% (2014)				n/a	↑	67% (2014) 70% (2015)	Alberta ranked 2nd best nationally for breast cancer and 8th for colorectal (out of 9 provinces)
Mental Health Readmissions: The percentage of mental health patients with unplanned readmission to hospital within 30 days of leaving hospital.	9.4%	9.6%	9.4%	9.3%	9.1% Q3 YTD	✔	9.5%	Alberta ranked 2nd best nationally (out of 10 provinces)
Surgery Readmissions: The percentage of surgical patients with unplanned readmission to hospital within 30 days of leaving hospital.	6.6%	6.6%	6.7%	6.5%	6.6% Q3 YTD	↓	6.3%	Alberta ranked 5th best nationally (out of 10 provinces)
Heart Attack Mortality: The percentage of patients dying in hospital within 30 days of being admitted for a heart attack.	6.5%	5.9%	7.2%	6.2%	6.2% Q3 YTD	→	5.9%	Alberta ranked 4th best nationally (out of 10 provinces)
Stroke Mortality: The percentage of patients dying in hospital within 30 days of being admitted for a stroke.	13.5%	15.0%	14.1%	13.9%	14.8% Q3 YTD	↓	13.2%	Alberta ranked 4th best nationally (out of 10 provinces)

Note: National Comparisons are based on the most recent data available, typically 2014-15. Parts of this material are based on data and information provided by the Canadian Institute for Health Information (CIHI). However, the analyses, conclusions, opinions and statements expressed herein are those of the author, and not necessarily those of the CIHI. Source for Early Detection of Cancer is the Canadian Community Health Survey (CCHS) for 2012.

Monitoring Measures

There are a number of measures monitored internally at AHS to help inform us about other areas of the health system. These monitoring measures do not have targets, and some of these measures do not have benchmarks across the country for comparison. However, these measures are familiar and of interest to Albertans. These measures are updated quarterly and posted on the AHS Data, Statistics and Reporting web page.

The measures presented below track our performance using a broad range of indicators that span the continuum of care. They include population and public health, primary care, continuing care, and access to cancer care, emergency department and surgery.

The following measures contribute to balanced performance monitoring and reporting that have been tracked over many years. AHS continues to collect and monitor these measures to help support priority setting and local decision-making. These measures are tactical as they inform the performance of an operational area, or reflect the performance of key drivers of a strategic measure.

The trend column indicates comparison of the most recent available data over the earliest data available for each measure: an upward arrow (↑) indicates improvement; a horizontal arrow (→) indicates stability and a downward arrow (↓) indicates areas that require additional focus.

LIFE EXPECTANCY	2011	2012	2013	2014	2015	Trend
The number of years a person would be expected to live, starting at birth, on the basis of mortality statistics. Both sexes combined.						
Provincial	81.6	81.7	81.7	81.8	81.9	→
First Nations	70.8	72.2	72.5	71.6	70.4	↓
Non-First Nations	82.0	82.0	82.1	82.2	82.3	→
Females	83.7	83.9	83.8	83.9	84.2	→
Males	79.4	79.5	79.6	79.7	79.6	→
POTENTIAL YEARS OF LIFE LOST	**2011**	**2012**	**2013**	**2014**	**2015**	**Trend**
The total number of potential years not lived by an individual who died before their 75th birthday.						
Total Population	43.4	43.1	42.8	44.5	45.4	↓
Females	33.6	32.9	33.9	34.8	34.0	↑
Males	52.8	52.8	51.5	53.8	56.2	↓
CANCER SCREENING PARTICIPATION RATES	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**Trend**
Breast	58.4%	57.1%	57.0%	56.1%	n/a	↓
Colorectal	53.2% (2012)	n/a	n/a	39.2%	n/a	↓
Cervical	63.5% (2010-12)	64.2% (2011-13)	62.7% (2012-14)	62.0% (2013-15)	n/a	↓

INFLUENZA IMMUNIZATION	2011-12	2012-13	2013-14	2014-15	2015-16	Trend
Rates of seasonal influenza immunization by age group.						
Children aged six to 23 months	29.9%	30.2%	35.7%	35.6%	35.9%	→
Adults aged 65 years and older	60.8%	60.0%	63.6%	60.5%	62.7%	↑
AHS Staff Influenza Immunization	n/a	n/a	60%	64%	61%	↓
CHILDHOOD IMMUNIZATION	**2011**	**2012**	**2013**	**2014**	**2015**	**Trend**
Rates of childhood immunization by two years of age in all service zones.						
Diphtheria/tetanus/acellular pertussis, polio, Hib	74.6%	74.9%	74.5%	75.6%	75.4%	→
Measles/mumps/rubella	85.5%	85.9%	85.9%	88.0%	87.1%	↓
PRIMARY CARE	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**Trend**
Albertans Enrolled in a Primary Care Network (%)	75% (April 2012)	76% (April 2013)	76% (April 2013)	79% (April 2015)	80% (April 2016)	↑
Ambulatory Care Sensitive Conditions*: Rate of hospital admissions per 100,000 for health conditions that may be prevented or managed by appropriate primary health care, under 75 years of age.	291	293	291	288	278	↑
Family Practice Sensitive Conditions: Percent of emergency department or urgent care visits for health conditions that may be appropriately managed at a family physician's office.	26.4%	26.0%	25.1%	24.3%	23.0%	↑
HEALTH INFORMATION	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**Trend**
Health Link: Percentage of calls to Health Link that are answered within two minutes.	81%	78%	79%	77%	76%	→
CHILDREN'S MENTAL HEALTH SERVICES	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**Trend**
Percent of children aged 0 to 17 years receiving scheduled mental health treatment within 30 days.	76%	80%	81%	82%	73%	↓
EMERGENCY DEPARTMENT	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**Trend**
Percentage of patients treated and discharged from the emergency department within 4 hours.						
Busiest 16 sites	65%	65%	66%	63%	63%	→
All sites	80%	80%	80%	78%	78%	→
Percentage of patients treated and admitted to hospital from the emergency department within 8 hours.						
Busiest 15 sites	45%	45%	46%	39%	41%	↑
All sites	55%	55%	54%	48%	49%	↑
CANCER WAIT TIME in weeks (90th percentile)	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**Trend**
Radiation Oncology Access: Referral to first consult (from referral to the time of their first appointment with a radiation oncologist).	5.3	4.9	4.9	4.9	5.0	↓
Medical Oncology Access: Referral to first consult (from referral to the time of their first appointment with a medical oncologist).	5.1	4.9	5.6	5.6	5.6	→

* AHS Ambulatory Care Sensitive Conditions (ACSC) rates differ from the Canadian Institute for Health Information's ACSC rates due to different methodologies for the population denominator.

SURGERY WAIT TIME (in weeks)	2011-12	2012-13	2013-14	2014-15	2015-16	Trend
Coronary Artery Bypass Graft Surgery Urgency III – Scheduled	28.8	25.9	21.5	23.7	19.8	↑
Cataract Surgery	37.3	31.6	31.6	33.3	35.9	↓
Hip Replacement Surgery	39.8	36.3	36.7	36.3	38.0	↓
Knee Replacement Surgery	48.0	40.9	41.9	44.9	43.9	↑
Hip Fracture Repair: % within 48 hours	84.4%	84.9%	88.4%	86.2%	90.0%	↑
CONTINUING CARE	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**Trend**
Total Number of People Placed into Continuing Care:	7,700	7,761	7,694	7,810	7,879	→
Number of patients placed from acute/subacute hospital bed into continuing care.	5,355	5,561	5,522	5,548	5,405	↓
Number of clients placed from community (at home) into continuing care.	2,345	2,200	2,172	2,262	2,474	↑
Average wait time in acute/subacute care hospital bed for continuing care placement (in days).	41	34	31	42	44	↓
Total Number Waiting For Continuing Care Placement:	1,469	1,154	1,193	1,544	1,411	↑
Number of persons waiting in acute subacute hospital bed for continuing care placement.	467	453	512	690	628	↑
Number of persons waiting in community (at home) for continuing care placement.	1,002	701	681	854	783	↑
Number of Unique Home Care Clients	104,516	109,184	112,062	114,990	116,462	↑

Financial Information

- Financial Statement Discussion and Analysis
- Consolidated Financial Statements
- Compensation Analysis and Discussion

Financial Statement Discussion and Analysis

For the year ended March 31, 2016

(in millions of dollars)

This Financial Statement Discussion and Analysis (FSD&A) is provided to enable readers to assess the results of Alberta Health Services' (AHS) operations and financial condition for the year ended March 31, 2016. In particular, the FSD&A reports to stakeholders how financial resources are being managed to provide a patient-focused, quality health system that is accessible and sustainable for all Albertans. It serves as an opportunity to communicate with stakeholders and other report users regarding AHS' 2015-16 financial performance, as well as significant financial policies, cost drivers, strategies, and plans to address financial risk and sustainability.

This FSD&A has been prepared by management and should be read in conjunction with the March 31, 2016 audited consolidated financial statements, notes, and schedules. The consolidated financial statements are prepared in accordance with Canadian Public Sector Accounting Standards (PSAS) and the Financial Directives issued by Alberta Health (AH). All amounts are in millions of dollars unless otherwise specified.

AHS' financial statements are prepared on a consolidated basis and include the following:

- 3 wholly owned subsidiaries: Calgary Laboratory Services Ltd., Capital Care Group Inc., and Carewest;
- 32 controlled foundations;
- Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP), and the Queen Elizabeth II Hospital Child Care Centre; and
- 50 percent (%) interest in the 42 Primary Care Networks (PCNs), 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) joint venture, and 30% interest in the HUTV Limited Partnership.

Additional information about AHS including financial reports from prior periods is available on the AHS website at www.ahs.ca.

2015-16 Financial Highlights

Recognizing the overall provincial fiscal climate and the economic challenges facing the province, AHS continues its efforts to manage costs and maximize benefits within available resources. AHS has continued its efforts in supporting core health services to meet the health care needs of Albertans, enhance effective service delivery, and develop business efficiency initiatives.

The demand for health care services continues to increase in Alberta, resulting in the need to expand programs and services at a time when AHS must continue to manage limited available resources. In order to achieve health system sustainability, AHS continues to focus efforts on financial sustainability. While expenses continue to increase, driven by a growing population, an aging population that is living longer, and health care inflation, the current fiscal rate of growth has decreased significantly compared to the average growth rate seen in the last eight years.

Did You Know?

- Alberta's population grew by 1.7 percent in 2015-16, which contributes to a growing need for health care services.
- Historically, AHS' expenses have increased by an average of over 6 percent per year.
- In 2015-16, expenses increased by 2.0 percent as compared to the prior year. For the next three years, expenses are budgeted to increase by an average of 1.7 percent per year.
- Health represents 39 percent of the provincial budget in Alberta and AHS accounts for 74 percent of this amount.

Following the change in provincial government in 2015, the 2015-16 provincial budget was approved during the third quarter of the current fiscal year. The AHS budget was approved by the Minister of Health on January 19, 2016.

AHS finished the year ended March 31, 2016 with a $145 annual deficit, representing one percent of total expenses. Expenses were higher than budgeted due to increased health care activity in areas such as home care, acute care, outpatient clinics and related diagnostic and therapeutic services, and a corresponding increase in staffing costs.

AHS continues to work internally and with external stakeholders, including Alberta Health (AH), to implement and realize ongoing operational efficiencies. More specifically, the implementation of Operational Best Practices (OBP) in 2016-17 will lead to further opportunities and improvements in the cost of delivering health care services, and support the long-term sustainability of the Alberta healthcare system.

Alignment to the Health and Business Plan

AHS continued to implement initiatives to meet health service needs across Alberta, helping to advance our three strategic directions.

1. Ensuring Quality of Care in Our Communities

- AHS has responded to the demand for continuing care by building and contracting new spaces across Alberta, having opened 997 net new continuing care spaces in 2015-16. Creating community capacity has significant positive impacts for clients who need continuing care, and also improves system flow for individuals who need emergency and acute care services by freeing up capacity.
- Additional home care visits and an increase in the number of home care clients further supported Albertans remaining within their homes and local communities, avoiding hospital admissions, and reducing the demand on acute care services.
- AHS made additional investments in cancer care, including the purchase of high-tech equipment such as linear accelerators as part of a multi-year purchase plan.

- AHS purchased several new ambulances and automated external defibrillators across Alberta, along with investments in ambulatory emergency information technology (IT) system projects.

II. Partnering for Better Health Outcomes

- As part of AHS' continuing efforts to improve patient experience, facility enhancements and upgrades were carried out to ensure that quality and safe care can continue to be provided to Albertans in clean and healthy environments.
- Spending continued on Infrastructure Maintenance Program projects as well as the procurement of equipment under the Medical Equipment Replacement and Upgrade Program.
- Continued focus on finding new, efficient and innovative ways of delivering health care in order to improve the healthcare system through Strategic Clinical Networks, PCNs, NACTRC, research, and education.

III. Achieving Health System Sustainability

- With a focus on achieving operational efficiencies and continuing to bend the cost curve, AHS completed significant planning to implement OBP in order to deliver high quality health care services efficiently and effectively. Although savings were not realized in 2015-16 as originally budgeted, AHS is committed to implementing OBP to support financial sustainability consistent with the 2016-17 Business Plan.
    - OBP is the practice of comparing AHS' cost of providing health care within Alberta, as well as externally to ensure overall efficiency and focus on quality care. Where necessary, changes will be made to improve practices and reduce costs.
    - The implementation of OBP will operate under the principles of no reduction in core front-line services, and the commitment to quality and continuous improvement in the healthcare system, while continuing to adhere to union collective agreements.
- Implementation of various information technology initiatives including increasing access to Alberta Netcare Portal (part of the provincial electronic health record), Clinical Telehealth services, upgrading existing information systems, and modernizing technological infrastructure and applications.
- AHS continued to address and invest in services to meet clinical needs, while reducing spending growth and achieving administrative efficiencies. Savings were realized in areas such as IT, energy management, and human resources.
- Strategic Clinical Networks are continuing to lead AHS in the development and implementation of clinical care pathways, which reduces variation in practice, improves outcomes, and spreads innovation.

As detailed throughout the annual report, these strategies continued to guide AHS in its delivery of health services throughout Alberta. Entering the second year of the 2015-2018 Health Plan and Business Plan, AHS will be required to implement significant business efficiencies, clinical efficiencies, and innovation in order to continue to manage expense growth. Further discussion on the future outlook, including long-term spending trends, risks, and sustainability can be found at the end of the FSD&A.

Financial Overview

Operations

2015-16 Highlights

- Total revenue was on budget and increased by less than one percent over 2014-15, with Alberta Health transfers accounting for 89% of total revenue.
- Total expenses were 1.1 percent higher than budget and increased by 2.0 percent over 2014-15.
- The $145 annual deficit represents 1 percent of total expenses or 3.7 days of operations.
- There was increased investment, as planned, for continuing care, community care, and home care - a 4.8 percent increase over 2014-15.
- Demand for inpatient and outpatient acute care continued to increase, albeit at a lower growth rate - a 2.2 percent increase over 2014-15.
- A positive insurance claims experience resulted in a 4.9 percent decrease in administration expense from 2014-15.

AHS' consolidated revenues in 2015-16 were $13,952, an increase of $128 as compared to 2014-15. The change was a result of increased funding received from AH and increased fees and charges, partially offset by a decrease in investment income. Relative to the budget, revenues as a whole came in as expected. Lower than budgeted operating grants were offset by higher than budgeted investment and other income.

AHS' consolidated expenses in 2015-16 were $14,100, an increase of $273 as compared to 2014-15. The change was a result of increased demand for services, inflation, collective bargaining increases, and the continued implementation of priority initiatives particularly in the areas of continuing care, community care, and home care, partially offset by a decrease in amortization expense. Similarly, expenses were $147 higher than budgeted largely due to increased activity and delays in the implementation of savings initiatives, which are expected to be realized through the implementation of OBP.

In 2015-16, the provision for healthcare services for Albertans cost AHS an average of $39 per day, based on annual expenditures of $14,100.

Financial Position

AHS' net debt position at March 31, 2016 was $89, an increase of $61 from the prior year, primarily as a result of increased liabilities exceeding available financial assets. A decrease in cash due to operating requirements mainly contributed to the overall decrease in financial assets.

Facilities, medical equipment, and information technology are integral to AHS' clinical and business processes and are key enablers for innovation and transformation. AHS continued to invest in various information technologies, as well as equipment purchases and upgrades in areas such as cancer care, Emergency Medical Services (EMS), and facilities.

The AHS accumulated surplus at March 31, 2016 was $1,159 and consists of four main components: unrestricted surplus, internally restricted surplus for future purposes, invested in tangible capital assets, and endowments.

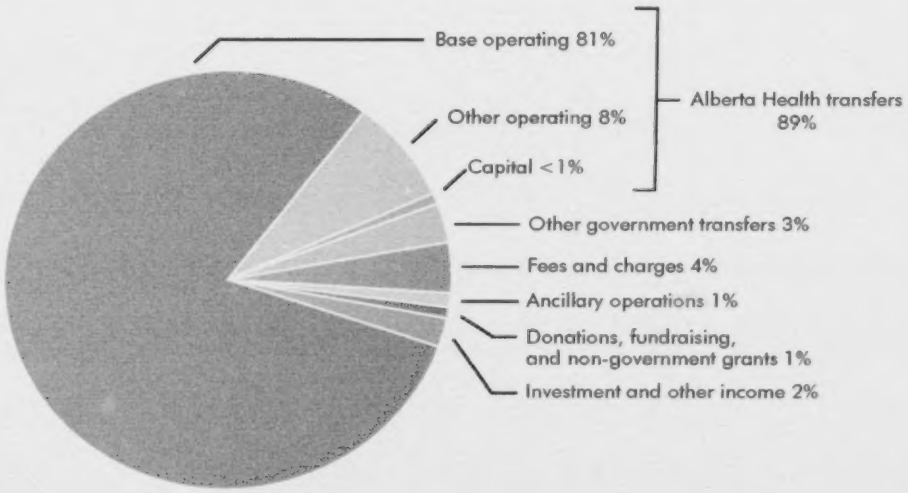
The unrestricted surplus at March 31, 2016 of $125 does not have any restrictions attached to its future use. Internally restricted surplus for future purposes of $281 has been restricted internally by AHS, as approved by the Board. Invested in tangible capital assets of $677 represents tangible capital assets purchased with internal funds, and endowments of $76 are externally restricted and must be maintained in perpetuity.

Financial Analysis

Statement of Operations

The Consolidated Statement of Operations shows the revenue earned by AHS and its application to provide health services.

Revenue



Total 2015-16 revenues increased by $128 or 0.9% from 2014-15 and were consistent with budgeted amounts. The overall increase in revenue from 2014-15 was primarily due to increased base operating transfers from AH, which is AHS' primary source of funding. The AH funding coverage was 89% (2014-15 – 89%), representing the percent of total expenses funded by AH in 2015-16.

REVENUE	Budget 2016	Actual 2016	Variance 2016		Actual 2015	Increase (Decrease)	
Alberta Health transfers	$12,524	$12,480	$(44)	(0.4%)	$12,322	$158	1.3%
Other government transfers	416	417	1	0.2%	421	(4)	(1.0%)
Fees and charges	507	491	(16)	(3.2%)	473	18	3.8%
Ancillary operations	132	133	1	0.8%	133	-	0%
Donations, fundraising, and non-government contributions	166	163	(3)	(1.8%)	167	(4)	(2.4%)
Investment and other income	208	268	60	28.8%	308	(40)	(13.0%)
Total revenue	**$13,953**	**$13,952**	**$(1)**	**0%**	**$13,824**	**$128**	**0.9%**

Significant variances and changes are explained as follows:

Alberta Health transfers are comprised of all AH transfers – unrestricted, restricted operating, and capital. Unrestricted AH transfers are the main source of operating funding to provide health care services to the population of Alberta. Restricted operating and capital funding can only be used for specific projects and are recognized when the related expenses are incurred.

ALBERTA HEALTH TRANSFERS	Budget 2016	Actual 2016	Variance 2016		Actual 2015	Increase (Decrease)	
Base operating	$11,330	$11,330	$ -	0%	$10,851	$479	4.4%
Other operating	1,110	1,065	(45)	(4.1%)	1,378	(313)	(22.7%)
Capital	84	85	1	1.2%	93	(8)	(8.6%)
Total AH transfers	**$12,524**	**$12,480**	**$(44)**	**(0.4%)**	**$12,322**	**$158**	**1.3%**

Base operating transfers amounted to $11,330, which is consistent with the budget.

Compared to the prior year, base operating transfers increased by $479 or 4.4% mainly due to supplemental base funding received in 2015-16 for the delivery of health services across Alberta, as well as the transition of the restricted grant for incremental operating costs of new health facilities into base operating funding.

Other operating transfers amounted to $1,065, which was $45 or 4.1% lower than the budget of $1,110 mainly due to vacancies and resident level mix differences in physician services programs, an increase in current year drug rebates, and delayed implementation of various initiatives primarily under Population and Public Health, Community, Seniors, Addiction & Mental Health, and Cancer Control Alberta. The overall variance was partially offset by increased activity in various clinical Alternative Relationship Plan programs.

Compared to the prior year, other operating transfers decreased by $313 or 22.7% primarily due to the transition of the restricted grant for incremental operating costs of new health facilities into base operating funding, and an increase in drug rebates associated with pharmaceutical grants. The overall decrease was partially offset by increases in physician compensation rates, increased activity in various programs, a higher volume of outpatient cancer drugs provided at no cost to patients, and an increased number of patients receiving services from PCNs.

Capital transfers amounted to $85, which was consistent with the budget.

Compared to the prior year, capital transfers decreased by $8 or 8.6%, primarily due to a decrease in amortization expense, against which revenue gets recognized.

Other government transfers are ongoing and one-time transfers for operating and capital purposes from federal, provincial (other than AH), and municipal governments.

Revenues from other government transfers were consistent with budget and the prior year.

Fees and charges revenue consists of patient revenue for health services provided at rates set by the Minister of Health and collected by AHS from individuals, Workers' Compensation Board (WCB), federal and provincial governments, and other parties, such as Alberta Blue Cross and insurance companies.

Fees and charges revenue amounted to $491, which was $16 or 3.2% lower than the budget of $507 mainly due to lower than budgeted activity and acuity related to services billable to WCB and other responsible parties. The overall variance was partially offset by increased revenue from out-of-country patient billings.

Compared to the prior year, fees and charges revenue increased by $18 or 3.8% mainly due to increased reciprocal billing rates, long-term care accommodation fees, and higher activity involving services provided to non-residents of Canada and patients receiving health insurance coverage from the federal government. The overall increase was partially offset by lower activity-related services billable to WCB.

Ancillary operations are the sale of goods and services that are unrelated to the direct provision of health services and include parking, non-patient food services, and rental operations.

Revenues from ancillary operations were consistent with budget and the prior year.

Donations, fundraising, and non-government contributions are comprised of revenue that can be unrestricted or restricted for operating or capital purposes. Restricted amounts received are recognized as revenue when the restrictions are met.

Revenues from donations, fundraising and non-government contributions were consistent with budget and the prior year.

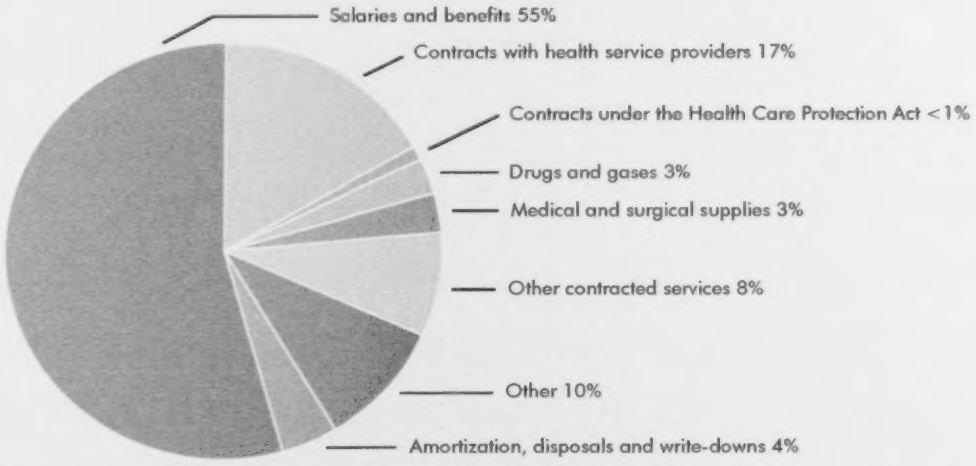
Investment and other income is comprised of interest income, dividends, net realized gains and losses on disposal of investments, and recoveries from external sources other than ancillary operations. Included are revenues from third parties, such as drug and medical supply companies and universities (for purposes other than research).

Investment and other income amounted to $268, which was $60 or 28.8% higher than the budget of $208 mainly due to growth in AHS' global equity market holdings which resulted in higher than budgeted dividends and realized gains, higher fixed income portfolio balances providing greater interest income, and higher than expected recoveries for services provided to external parties. The overall variance was also the result of unbudgeted surplus distribution revenue from the WCB, and higher physician fees assigned to AHS in relation to income guarantee agreements.

Compared to the prior year, investment and other income decreased by $40 or 13% mainly due to investment market forces which resulted in lower returns from Canadian and US equity markets and interest income from fixed income investments, and decreased restricted revenue recognized from minor equipment purchases.

Expenses – By Object

AHS reviews and reports operating expenses by object and by function in order to fully describe the results of current operations, strategic priorities, and new investments.


Salaries and benefits 55%
Contracts with health service providers 17%
Contracts under the Health Care Protection Act <1%
Drugs and gases 3%
Medical and surgical supplies 3%
Other contracted services 8%
Other 10%
Amortization, disposals and write-downs 4%

The overall distribution of expenses by object has remained consistent with prior years, with salaries and benefits making up more than half of total expenses (2014-15 – 55%). Expenses continue to be driven by salaries and benefits within both AHS and contracts with health service providers.

During 2015-16, AHS incurred increased costs, relative to the budget and the prior year, related to salaries and benefits and contracts with health service providers, and saw increased activity in various areas across the province. The overall increase in expenses was partially offset by vacancies.

EXPENSES	Budget 2016	Actual 2016	Variance 2016		Actual 2015	Increase (Decrease)	
Salaries and benefits	$7,611	$7,742	$(131)	(1.7%)	$7,532	$210	2.8%
Contracts with health service providers	2,409	2,451	(42)	(1.7%)	2,376	75	3.2%
Contracts under the Health Care Protection Act	18	19	(1)	(5.6%)	19	-	0%
Drugs and gases	427	417	10	2.3%	412	5	1.2%
Medical and surgical supplies	390	414	(24)	(6.2%)	404	10	2.5%
Other contracted services	1,164	1,134	30	2.6%	1,138	(4)	(0.4%)
Other expenses	1,316	1,334	(18)	(1.4%)	1,313	21	1.6%
Amortization, disposals and write-downs	618	589	29	4.7%	633	(44)	(7.0%)
Total expenses	**$13,953**	**$14,100**	**$(147)**	**(1.1%)**	**$13,827**	**$273**	**2.0%**

Significant variances and changes are explained as follows:

Salaries and benefits are comprised of compensation for hours worked, vacation and sick leave, other cash benefits (which includes overtime), employer benefit contributions made on behalf of employees, and severance.

Salaries and benefits amounted to $7,742, which was $131 or 1.7% higher than the budget of $7,611 mainly due to shift differential and weekend premium rate differences, increased activity across the organization resulting in the need for increased worked hours, and delayed implementation of OBP initiatives. This variance was partially offset by savings due to vacant positions throughout AHS, including both hard-to-recruit positions and regular recurring vacancies.

Compared to the prior year, salaries and benefits increased by $210 or 2.8% mainly due to salary rate increases related to collective agreement ratifications, and a 1% increase in worked hours, which also resulted in increased benefit costs. Higher costs were also incurred compared to prior year in order to address increased activity in certain areas of AHS, including inpatient days, home care hours, and the opening of new beds and units under the Continuing Care Capacity Plan. Further contributing to the overall increase was the addition of one extra day of health services due to 2016 being a leap year. Although the number of clinical employees increased compared to the prior year, vacancies persisted throughout AHS resulting in increased costs for casual relief. The overall increase was partially offset by the achievement of cost containment strategies and reduced overtime.

Calculated Full Time Equivalents (FTE) amounted to 77,007 FTE compared to the prior year of 75,955 FTE, resulting in an increase of 1,052 or 1.4%. Calculated FTEs are determined by actual hours earned divided by 2,030.50 annual base hours for fiscal 2016, which is an increase from the previous 2,022.75 annual base. The increase in the annual base hours was due to 2016 being a leap year, resulting in one additional day in the current year. The overall increase in FTEs was primarily due to increased worked and relief hours. The clinical areas account for 48,128 FTEs, which was an increase of 1.8% as compared to the prior year. Other Staff, which include support services such as food services, facilities and maintenance, clerical staff, and secretarial support, account for 25,708 FTEs, which was a 0.8% increase as compared to the prior year. Total management account for 3,148 FTEs, which is a decrease of 0.5% as compared to the prior year.

Contracts with health service providers include voluntary and private health service providers with whom AHS contracts for health services, such as long-term care facilities, home care providers and lab service providers.

Contracts with health service providers amounted to $2,451, which was $42 or 1.7% higher than the budget of $2,409 mainly due to increased activity, particularly related to the expansion of home care services in response to increased home care clients, resulting in increased vendor hours. While AHS continued to create community capacity, timing delays in the opening of continuing care beds partially offset the overall variance.

Compared to the prior year, contracts with health service providers increased by $75 or 3.2% mainly due to increased activity, particularly in home care and the addition of 997 net new continuing care beds as a result of planned initiatives such as the Continuing Care Capacity Plan. Further contributing to the increased costs was inflation, including collective agreement costs, resulting in contract rate increases primarily related to lab services, continuing care, mental health, and other specialty contracts.

Contracts under the Health Care Protection Act relates to contracts with surgical facilities pursuant to the *Health Care Protection Act* which ensures quality while promoting the delivery of publicly funded services by allowing contracting out to profit-orientated surgical facilities.

Costs associated with the Contracts under the Health Care Protection Act were consistent with budget and the prior fiscal year.

Drugs and gases includes all drugs used by AHS, including medicines, certain chemicals, anaesthetic gas, oxygen, and other medical gases used for patient treatment. Drugs not used for patient treatment such as diagnostic reagents, are not included in this category, and are reported in other expenses.

Drugs and gases amounted to $417, which was $10 or 2.3% lower than the budget of $427, mainly due to increased outpatient cancer drug rebates and generic drug price changes. The overall variance was partially offset by increased activity across all Zones and programs resulting in significant growth in drug utilization, including increased cancer treatments.

Compared to the prior year, drugs and gases increased by $5 or 1.2% mainly due to increased activity related to cancer treatments, including the purchase of new and specialized high cost drugs. The overall increase was partly offset by increased outpatient cancer drug rebates as compared to the prior year, as well as price changes on certain specialized high cost drugs.

Medical and surgical supplies include prostheses, instruments used in surgical procedures and in treating and examining patients, sutures, and other supplies.

Medical and surgical supplies amounted to $414, which was $24 or 6.2% higher than the budget of $390 mainly due to increased activity in the Zones, primarily related to operating room (OR) and surgical activity, and renal programs.

Compared to the prior year, medical and surgical supplies increased by $10 or 2.5% mainly due to increased activity in the larger Zones, primarily related to surgical procedures and patient volumes; this increase was partially offset by the achievement of cost containment strategies.

Other contracted services are payments to those under contract that are not considered to be employees. This category includes payments to physicians for referred-out services and purchased services, as well as home support contracts and various self-managed care contracts.

Other contracted services amounted to $1,134, which was $30 or 2.6% lower than the budget of $1,164 mainly due to hard-to-recruit physician vacancies. Further contributing to the variance was the cancellation of certain Information Technology contracted services as these services are now being performed in house. Timing variances associated with the implementation of various budgeted initiatives, including CoACT and Quality Initiative programs, further contributed to the variance, including the continued achievement of cost control strategies put into practice in the prior year. The overall variance was partially offset by increased activity in various areas including diagnostic imaging and the Academic Alternative Relationship Plan.

Other contracted services were consistent with the prior fiscal year.

Other expenses relate to those not classified elsewhere.

Other expenses amounted to $1,334, which was $18 or 1.4% higher than the budget of $1,316 mainly due to delayed implementation of OBP initiatives, additional Infrastructure Maintenance Program projects, higher than budgeted expenses for AHS' share of the PCN expenses, and higher IT costs. The overall variance was partially offset by savings in utilities and decreased insurance expenses associated with claims settling at lower than expected amounts.

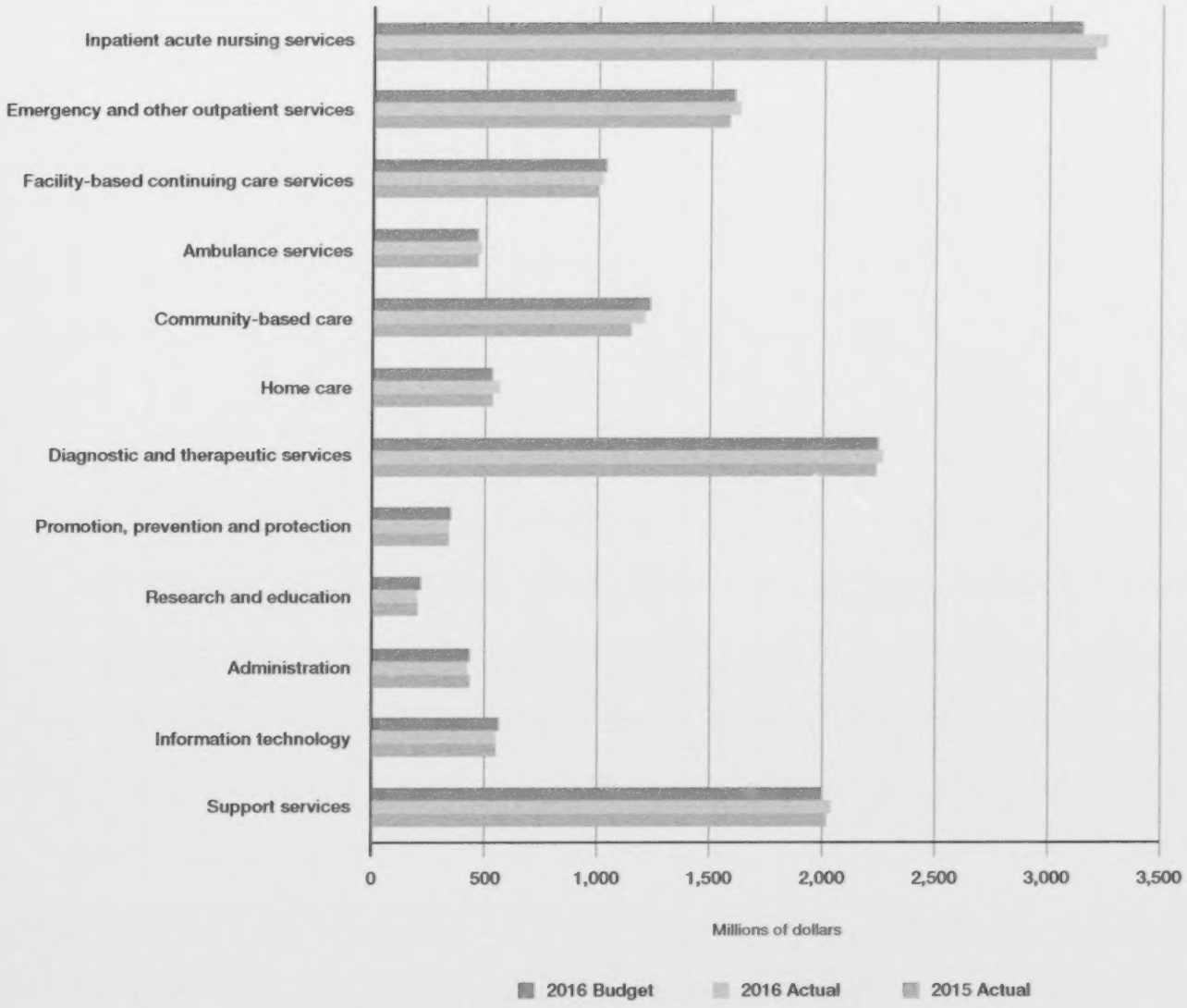
Compared to the prior year, other expenses increased by $21 or 1.6% mainly due to increased costs related to controlled foundations activities, AHS' share of expenses for the PCNs, infrastructure and equipment maintenance, minor equipment, and IT projects. Further contributing to the overall increase was the inflationary impact on various contracts as well as parking operations costs. The overall increase was partially offset by achieved savings initiatives, including reduced overhead and administrative costs, decreased insurance expenses, as well as reduced utility costs as a result of lower natural gas prices and implementation of utility efficiency projects.

Amortization, disposals and write-downs relate to the periodic charges to expenses representing the estimated portion of the cost of the respective tangible capital asset that expired through use and age during the period.

Amortization expenses amounted to $589, which was $29 or 4.7% lower than the budget of $618 mainly due to timing differences between anticipated and actual deployment of building service equipment, changes to expected completion costs and timelines of IT system projects, as well as delays between anticipated and actual purchases of major equipment. Additionally, capitalized costs from new facilities projects during the current fiscal year were lower than expected, contributing to lower amortization expense.

Compared to the prior year, amortization expenses decreased by $44 or 7.0%, mainly due to a decrease in the addition of equipment, IT tangible capital assets, various construction projects, and existing AI managed projects.

Expenses – By Function



The overall 2.0% increase in 2015-16 expenses was primarily due to increased salary and benefit costs and contracts with health service provider costs, offset by a decrease in amortization expense. AHS' overall distribution of expenses has remained consistent with previous years, with inpatient acute nursing services and diagnostic and therapeutic expenses making up 39% of total expenses.

Total expenses have increased annually due to continued cost pressures such as salary rate increases related to collective agreement ratifications, increased activity, new investments, inflation, and new facilities.

EXPENSES	Budget 2016	Actual 2016	Variance 2016		Actual 2015	Increase (Decrease)	
Inpatient acute nursing services	$3,157	$3,269	$(112)	(3.5%)	$3,214	$55	1.7%
Emergency and other outpatient services	1,619	1,635	(16)	(1.0%)	1,586	49	3.1%
Facility-based continuing care services	1,047	1,035	12	1.1%	1,006	29	2.9%
Ambulance services	468	478	(10)	(2.1%)	475	3	0.6%
Community-based care	1,222	1,206	16	1.3%	1,138	68	6.0%
Home care	542	568	(26)	(4.8%)	536	32	6.0%
Diagnostic and therapeutic services	2,248	2,275	(27)	(1.2%)	2,235	40	1.8%
Promotion, prevention and protection Services	379	363	16	4.2%	361	2	0.6%
Research and education	240	224	16	6.7%	235	(11)	(4.7%)
Administration	454	426	28	6.2%	448	(22)	(4.9%)
Information technology	566	565	1	0.2%	569	(4)	(0.7%)
Support services	2,011	2,056	(45)	(2.2%)	2,024	32	1.6%
Total expenses	**$13,953**	**$14,100**	**$(147)**	**(1.1%)**	**$13,827**	**$273**	**2.0%**

Significant variances and changes are explained as follows:

Inpatient acute nursing services are comprised predominantly of nursing units such as medical, surgical, intensive care, obstetrics, paediatrics, and mental health. This category also includes operating and recovery rooms.

Inpatient acute nursing services amounted to $3,269, which was $112 or 3.5% higher than the budget of $3,157 due to delayed implementation of OBP initiatives, increased activity levels related to Alternative Relationship Plans, unfunded transition beds and units, and Zone activity, including increased elapsed patient days, OR, and surgical activity. Increased activity also resulted in compensation rate variances due to shift premiums and relief coverage. The overall variance was partially offset by vacancies related to physician and staff positions.

Compared to the prior year, inpatient acute nursing services increased by $55 or 1.7% mainly due to increased compensation costs related to collective agreements, as well as increased stipends paid to physicians. While elapsed patient days remained relatively constant as compared to the prior year, increases in various other activities, including surgery and OR cases, increased staffing costs including compensation rate variances and relief coverage. There was also increased activity under the Alternative Relationship Plans and annualizations of capacity as respective hospital beds were now in operation for the entire fiscal year. The overall increase was partially offset by savings due to the achievement of cost containment strategies, including the reduction of overtime costs.

Emergency and other outpatient services are comprised primarily of emergency, day/night care, clinics, day surgery, and contracted surgical services.

Emergency and other outpatient services amounted to $1,635, which was $16 or 1.0% higher than the budget of $1,619 mainly due to increased cancer drug utilization within medical speciality clinics, delayed implementation of OBP initiatives, and an increase in activity, particularly within clinics and to a lesser extent, emergency visits. Further contributing to the variance were compensation rate variances due to shift premiums. The overall variance was partially offset by increased outpatient cancer drug rebates, vacancies, and market rate fluctuations for high cost drugs.

Compared to the prior year, emergency and other outpatient services increased by $49 or 3.1% mainly due to increased drug utilization as several new cancer drugs were made available in the current year. The increase in activity amongst various areas including the OR, Cardiac Sciences, and day medicine clinics also contributed to the increase in drug usage and overall costs. While emergency visits decreased year-over-year, this was offset by an increase in the number of urgent visits as compared to non-urgent visits. Increased compensation costs related to collective agreements, increased activity for Alternative Relationship Plans, and reduced general vacancies also contributed to the increases in the current year. Alternatively, generic drug price reductions and rebates offset increases experienced in specialized high cost drugs.

Facility-based continuing care services are comprised of long-term care including chronic and psychiatric care operated by AHS and contracted providers.

Facility-based continuing care services amounted to $1,035, which was $12 or 1.1% lower than the budget of $1,047 mainly due to timing delays in the opening of new beds.

Compared to the prior year, facility-based continuing care services increased by $29 or 2.9% due to increased capacity, higher contract costs as a result of inflation, and increased compensation costs related to collective agreements.

Ambulance services are comprised of Emergency Medical Services (EMS) ambulance, patient transport, and EMS central dispatch.

Ambulance services amounted to $478, which was $10 or 2.1% higher than the budget of $468 mainly due to shift differentials, premium rate differences and higher relief coverage, as well as increased activity, including the extension of dispatch contracts, which were budgeted to be partial year contracts. The overall variance was partially offset by vacancies.

Ambulance services were consistent with the prior fiscal year.

Community-based care is comprised primarily of supportive living, and palliative and hospice care, but excludes community-based dialysis, oncology, and surgical services. This category also consists of community programs including Primary Care Networks, Family Care Clinics, urgent care centres, and community mental health.

Community-based care amounted to $1,206, which was $16 or 1.3% lower than the budget of $1,222 mainly due to vacancies in the Zones, delays in various budgeted initiatives, particularly the Continuing Care Capacity Plan, and the achievement of cost control strategies in the Zones.

Community-based care increased by $68 or 6.0% over the prior year mainly due to increased capacity and the annualized impact of initiatives under the Continuing Care Capacity Plan. These initiatives were fully operational for the current year, resulting in increased costs year over year. Additionally, increased compensation costs related to collective agreements resulted in higher costs in the current year. The overall increase was partially offset by vacancies related to program grants.

Home care is comprised of home nursing and support.

Home care amounted to $568, which was $26 or 4.8% higher than the budget of $542 mainly due to an increase in home care activity across the Zones stemming from increased demand resulting in increased home care hours and the use of relief staff. The overall variance was offset by vacancies.

Home care increased by $32 or 6.0% from the prior year mainly due to increased activity resulting from increased home care clients and unique client visits. Compensation costs related to collective agreements further contributed to the increased costs in the current year.

Diagnostic and therapeutic services are comprised primarily of clinical lab (both in the community and acute facilities), diagnostic imaging, pharmacy, acute and therapeutic services such as physiotherapy, occupational therapy, respiratory therapy, and speech language pathology.

Diagnostic and therapeutic services amounted to $2,275, which was $27 or 1.2% higher than the budget of $2,248 mainly due to increased activity throughout AHS, including increased referred-out specialized testing, changes in the mix of exams resulting in higher costing procedures and staff premiums. The overall variance was partially offset by vacancies for both general and hard-to-recruit positions, and timing delays in the implementation of service contracts, as well as a reduction in overtime as various areas and the Zones looked to reduce its utilization.

Compared to the prior year, diagnostic and therapeutic services increased by $40 or 1.8% mainly due to compensation increases related to collective agreements, increased activity throughout the organization, contract inflation including lab services, and a reduction in vacant positions compared to the prior year.

Promotion, prevention and protection services are comprised primarily of health promotion, disease and injury prevention, and health protection.

Promotion, prevention and protection services amounted to $363, which was $16 or 4.2% lower than the budget of $379 mainly due to vacancies and delays in various budgeted initiatives including the Cancer Alberta Project, Alberta Community Wellness, Healthy Behaviours, and Lifestyles Survey Project.

Promotion, prevention and protection services were consistent with the prior fiscal year.

Research and education pertains to formally organized health research and graduate medical education, primarily funded by donations, and third party contributions.

Research and education amounted to $224, which was $16 or 6.7% lower than the budget of $240 mainly due to physician vacancies, which was partially offset by an increase in spending under special purpose funds.

Compared to the prior year, research and education decreased by $11 or 4.7% mainly due to a shift of funding and activity from a foundation to a post-secondary institution.

Administration is comprised of human resources, finance, communications and general administration, as well as a share of administration of certain contracted health service providers. General administration includes senior executives and various functions such as planning and development, infection control, quality assurance, patient safety, insurance, privacy, risk management, internal audit, and legal. Activities and costs directly supporting clinical activities are excluded.

In 2015-16, AHS' administration expense was $426 which represents 3.0% (2014-15 – 3.2%) of total expenses.

The Canadian Institute for Health Information (CIHI) reports administration expense as a financial performance indicator calculated based on administration expense net of recoveries, and total expenses net of recoveries and inclusive of bad debt expense. For 2015-16, AHS' indicator was 3.0% (2014-15 – 3.2%).

Administration amounted to $426, which was $28 or 6.2% lower than the budget of $454 mainly due to administrative-related vacancies throughout AHS, further heightened by the hiring restraint in effect throughout the year. Further contributing to the overall variance were lower than budgeted insurance expenses associated with the settlement of claims, various delays in budgeted initiatives, including collaborative care initiatives under CoACT, and the achievement of cost containment efforts including reduced travel expenses and supply costs. Offsetting the overall variance were various one-time expenses including renovations and Employee and Family Assistance Program utilization.

Compared to the prior year, administration decreased by $22 or 4.9% mainly due to a reduction in insurance expenses associated with lower actuarial estimates for claims development, as well as favourable claims development and lower than expected payouts on active claims, general vacancies, and achievement of cost containment strategies.

Information technology are costs pertaining to the provision of services to design, develop, implement, and maintain effective and efficient management support systems in the areas of data processing, systems engineering, technical support, and systems research and development. This includes clinical and corporate enterprise systems and infrastructure, as well as support of provincial systems such as Alberta Netcare, the electronic health record.

Information technology costs were consistent with the budget and prior fiscal year.

Support services are comprised of building maintenance operations (including utilities), materials management (including purchasing, central warehousing, distribution and sterilization), housekeeping, laundry and linen services, patient registration, health records, food services, and emergency preparedness.

Support services amounted to $2,056, which was $45 or 2.2% higher than the budget of $2,011 mainly due to delayed implementation of OBP initiatives, increased activity and completion of projects, particularly with respect to the Infrastructure Maintenance Program, and increased capital management activity, including parking operations projects. The overall variance was partially offset by vacancies, reduced utility costs, and lower than anticipated amortization related to facilities and improvements.

Compared to the prior year, support services increased by $32 or 1.6% mainly due to costs related to minor equipment and service contracts, increased Infrastructure Maintenance Program costs, compensation costs related to collective agreements, and the completion of increased parking projects. The overall increase was partially offset by lower amortization expenses due to lower asset additions, reduced utility costs, and the achievement of cost containment strategies.

Statement of Financial Position

CONSOLIDATED STATEMENT OF FINANCIAL POSITION	Actual 2016	Actual 2015	Increase (Decrease)
Cash	$80	$332	$(252)
Portfolio investments	2,188	2,173	15
All other financial assets	405	326	79
Total financial assets	**2,673**	**2,831**	**(158)**
Unexpended deferred operating revenue	430	491	(61)
Unexpended deferred capital revenue	148	178	(30)
Debt	327	322	5
All other liabilities	1,857	1,868	(11)
Total liabilities	**2,762**	**2,859**	**(97)**
Net debt	**(89)**	**(28)**	**(61)**
Tangible capital assets	7,573	7,511	62
Inventories for consumption	94	97	(3)
Prepaid expenses	116	127	(11)
Total non-financial assets	**7,783**	**7,735**	**48**
Expended deferred capital revenue	6,530	6,364	166
Net assets	**$1,164**	**$1,343**	**$(179)**
Accumulated surplus	$1,159	$1,304	$(145)
Accumulated remeasurement gains and losses	5	39	(34)

AHS prepares its financial statements using the net debt presentation. In prior years, the net asset presentation was followed. Moving to the net debt presentation primarily rearranges the line presentation on the Consolidated Statement of Financial Position, with an emphasis on financial vs. non-financial assets. Furthermore, use of the net debt presentation requires the inclusion of the Statement of Changes in Net Debt.

Net debt provides a measure of the future revenues required by AHS to pay for past transactions and services. It provides information regarding the extent to which the expenditures of the accounting period are met by the revenues recognized in the Consolidated Statement of Operations.

Financial Assets

Financial assets are the financial resources available to AHS for settling its liabilities.

Cash & Portfolio Investments

AHS receives its base operating funding from AH on a semi-monthly basis. The arrangement allows AHS to manage its operating cash balances effectively to meet its immediate and ongoing liabilities as they become due. The AHS investment portfolio is conservative and highly liquid in nature and enables AHS to react to expected and unexpected cash requirements quickly and efficiently. Focusing on prudent stewardship of funds, AHS monitors its bank balances closely and transfers cash to or from the investment portfolio to ensure that cash balances earn maximum returns until they need to be utilized.

Cash and portfolio investments decreased during the year by $237 due to operating requirements and a slight decrease in restricted grant funding received from AH year over year. AHS' investment portfolio also benefited from portfolio rebalancing during the year resulting in a slight shift towards global equities. The portfolio experienced total income returns of 3.7% during 2015-16 (2014-15 – 4.4%).

The cash and portfolio investment balance of $2,268 will be used to cover future liabilities including accounts payable and accrued liabilities, deferred operating and capital costs, and long-term borrowing obligations.

As at March 31, 2016, management believes that the current balance is appropriate to cover immediate and upcoming obligations as they become due.

Investment Philosophy

AHS has an investment philosophy designed to ensure that its funds are invested in a way that promotes the short and long-term sustainability of AHS' operations. This investment philosophy assures preservation of capital by minimizing exposure to undue risk of loss or impairment, while maintaining a reasonable expectation of fair return or appreciation while offsetting the effects of inflation. This strategy protects the original capital while providing reasonable returns with a conservative exposure to more volatile equity markets.

Other Financial Assets

Other financial assets are comprised of accounts receivable and other assets. The overall increase in other financial assets was mainly attributed to an increase in accounts receivable, driven by an increase in the grants receivable from AH and AI, as well as an increase in drug and other rebates.

Liabilities

Liabilities are existing financial obligations at the date of the financial statements. They result from past transactions and events and will lead to the future use of economic resources.

Unexpended Deferred Operating Revenue

Unexpended deferred operating revenue is comprised of unspent operating funds that have been received by AHS for which spending restrictions, imposed by a funder or donor, exist. During the year, AHS received or accrued, net of repayments and interest income, $1,218 in restricted funding. An additional $48 was transferred from unspent capital funding to fund operating initiatives. AHS recognized $1,327 of revenue, reflecting the amount spent in related expenses.

Unexpended Deferred Capital Revenue

Unexpended deferred capital revenue is comprised of unspent capital funds that have been received by AHS for which spending restrictions, imposed by donors, exist. During the year, AHS received or accrued, net of repayments, $590 in restricted capital funding. At the same time, AHS incurred $572 in expenditures and transferred $48 in capital funding to fund operating initiatives as previously noted.

Debt

AHS issues debentures to Alberta Capital Finance Authority (ACFA) to finance the construction of parking facilities. AHS pledges the revenue derived from all parking facilities as security for the debentures. During the year, $20 in debt proceeds was received to finance the construction of a parking facility at the Red Deer Regional Hospital Centre.

The net principal repayments in the year on all outstanding debt amounted to $15.

AHS has access to a $220 revolving demand loan facility with a Canadian chartered bank, which may be used for operating purposes. This facility was not utilized during the year. Additionally, AHS has access to a $33 revolving demand letter of credit facility of which $3 in letters of credit were outstanding as at March 31, 2016 (March 31, 2015 - $3).

Other Liabilities

Other Liabilities is comprised of accounts payable, accrued liabilities, and employee future benefits. The decrease from prior year of $11 was attributable to payroll remittances payable and accrued liabilities, which declined by $28 primarily due to the timing of pay periods at year end. Accounts payable balances also declined by $9, offset by an increase in accrued employee future benefits of $26.

Non-Financial Assets

Non-financial assets are assets that AHS consumes when providing services to the public and are not intended to be used for settling its liabilities with external parties.

Tangible Capital Assets

TANGIBLE CAPITAL ASSETS	Actual 2016	Actual 2015	Increase
Cost	$14,054	$13,568	$486
Accumulated amortization	6,481	6,057	424
Net book value	**$7,573**	**$7,511**	**$62**

Over the course of the year, several capital projects totalling $272 included in work in progress were brought into service. Notable projects included the Edson Health Care Centre, Red Deer Regional Hospital Centre Parkade, Foothills McCaig Tower – 7th Floor Calgary Laboratory Services, South Hospital Post Construction, Fort McMurray Detox Centre, Northern Lights Hospital Emergency / ICU Renovations, Alberta Ambulatory EMR, and IT Network Services Equipment projects.

The WIP balance includes infrastructure and IT capital projects at the following sites:

- Grande Prairie Regional Hospital
- Medicine Hat Regional Hospital
- Stollery Children's Hospital
- Edson Healthcare Centre
- High Prairie Health Complex
- Lethbridge Chinook Regional Hospital
- Royal Alexandra Hospital
- Foothills Medical Centre
- Taber Health Centre
- Peter Lougheed Centre
- Northern Alberta Urology Centre
- Misericordia Community Hospital
- Medicine Hat Detox Resident Treatment Centre

At March 31, 2016, AHS approved capital commitments for purchases of tangible capital assets of $74 for facilities and improvements, $15 for information systems, and $66 for equipment.

The capital purchases compared to the annual amortization expense indicates the rate of reinvestment. The reinvestment rate for equipment and information systems was 39% in 2015-16 (2014-15 – 46%). The reduced rate was due to a decrease in purchases compared to the prior year. As a result, the estimated remaining useful life for equipment and information systems decreased from 2.7 years in 2014-15 to 2.4 years in 2015-16.

Financing of Tangible Capital Assets

AHS primarily relies on transfers from AI for funding capital expenditures. Equipment purchases were 69% externally funded (2014-15 – 47%) and information system purchases were 51% externally funded (2014-15 – 31%).

Expended Deferred Capital Revenue

Expended deferred capital revenue represents unrecognized funding for purchased tangible capital assets which AHS is required to utilize for the duration of their economic useful lives. These assets include hospitals and other related facilities, equipment and information systems. Funding from the GOA, mainly AI, contributed to $6,056 (93%) of the $6,530 total balance.

Accumulated Surplus

	Actual 2016	Actual 2015	Increase (Decrease)
Accumulated surplus	$1,159	$1,304	$(145)
Less: Invested in tangible capital assets	(677)	(804)	127
Less: Internally restricted surplus for future purposes	(281)	(155)	(126)
Less: Endowments	(76)	(73)	(3)
Unrestricted surplus	**$125**	**$272**	**$(147)**

The unrestricted surplus of $125 at March 31, 2016 does not have any restrictions attached to its future use and may be used at AHS' discretion for operating or capital purposes.

The accumulated surplus invested in tangible capital assets at March 31, 2016 of $677 represents the net book value of tangible capital assets that have previously been purchased with AHS' unrestricted surplus. Assets invested in tangible capital assets are not available to be monetized to cover future operations.

The internally restricted surplus for future purposes at March 31, 2016 of $281 has been set aside for future operating and capital purposes.

The endowments of $76 are comprised of financial resources received by AHS where the principal amount is maintained in perpetuity and investment income earned on the principal is available for use as stipulated by the endowment donors. Endowment contributions in the year amounted to $3.

Historical 5-Year Information

Select Annual Financial Information					
Years Ended March 31					
	Actual 2016	Actual 2015	Actual 2014	Actual 2013	Actual 2012
Revenue	$13,952	$13,824	$13,218	$12,684	$11,853
Expenses	14,100	13,827	13,062	12,578	11,766
Annual operating surplus (deficit) before endowment contributions	(148)	(3)	156	106	87
Endowment contributions	3	4	3	1	4
Annual surplus (deficit)	**$(145)**	**$1**	**$159**	**$107**	**$91**
Accumulated surplus	$1,159	$1,304	$1,303	$1,144	$1,037

Financial Reporting, Control and Accountability

Financial Reporting

Alberta Health Services was established under the Regional Health Authorities Act (Alberta), effective April 1, 2009, as a result of the amalgamation of 12 formerly separate health entities in Alberta.

The AHS consolidated financial statements have been prepared in accordance with PSAS and the financial directives issued by Alberta Health. The chart of accounts that AHS uses to report expenses by program and by object is based on the national standard of CIHI. Detailed site-based results are submitted to CIHI annually for analysis and reporting on Canada's health system and the health of Canadians. AHS' annual financial reports are available at www.ahs.ca under data, statistics, and reporting.

The Auditor General of Alberta is the appointed auditor of AHS. In addition to expressing an audit opinion on the AHS annual consolidated financial statements, the Auditor General of Alberta also reports recommendations to the legislature related to AHS along with other government entities. The Auditor General of Alberta's reports are available at www.oag.ab.ca under public reports.

Financial Control and Accountability

An effective, integrated governance model is an essential component in support of improving:

- the delivery of care and services to Albertans;
- support for people who deliver care and services; and
- the way the organization operates.

AHS performance measures are aligned with the Alberta Quality Matrix for Health, a framework that provides a common language, understanding and approach for thinking about quality among health-care organizations, professionals and other stakeholders.

The Board provides oversight and carries out its risk management mandate primarily through sub committees, which include the Audit & Risk Committee, Finance Committee, Quality & Safety Committee, Governance Committee, Human Resources Committee, and Community Engagement Committee.

The Audit & Risk Committee has responsibility to assist in fulfilling oversight responsibilities of the Board with respect to management and compliance, external financial reporting, internal controls over financial reporting, internal audit, and the external audit. The Finance Committee has responsibility to assist in fulfilling the financial oversight responsibilities of the Board and in overseeing management's administration of AHS on finance related items, such as its investment portfolio.

AHS has established an Internal Audit function with the mandate of providing independent assurance to management and the Board on AHS operations. The scope of Internal Audit's work is to determine whether AHS' risk management, control and governance processes are adequate and functioning effectively. The Chief Audit Executive is also responsible for coordinating AHS' Enterprise Risk Management function including development and implementation of policy and processes for identifying, monitoring and reporting risks within the organization.

As a component of the Internal Audit function, AHS has an Internal Controls over Financial Reporting (ICOFR) group, which is tasked with ensuring that the financial reporting environment mitigates the risk of material misstatements by establishing a sustainable framework of internal controls over financial reporting. In fulfilling its mandate, ICOFR continues to work on the implementation of its plan to ensure that appropriate internal controls are designed, implemented, and documented within AHS.

Forward-Looking Statements Disclosure

The FSD&A includes forward-looking statements and information about the organization's outlook, direction, operations, and future financial results that are subject to risks, uncertainties, and assumptions. As a consequence, actual results in the future may differ materially from any conclusion, forecast or projection in such forward-looking statements. Therefore, forward-looking statements should be considered carefully and undue reliance should not be placed on them.

Outlook

Long-term Spending Trends, Cost Drivers, and Sustainability

For future years, key considerations are:

- Historically, AHS' expenses have grown by over 6 percent per year.
- For 2016-2019, expenses are budgeted to grow by less than 2 percent per year.
- AHS' most significant cost drivers will continue to be population growth, collective agreement settlements, and inflation, which will result in significant cost pressures.
- AHS must continue to invest in priority services to meet clinical needs, address service pressures, implement strategic innovations, and address enterprise risks.

To achieve financial sustainability, AHS will achieve efficiencies in order to free up resources for needed investments.

In the short-term, AHS will focus on achieving business efficiencies through Operational Best Practices. Continuing work underway since it was formed, AHS will continue to identify and eliminate inefficiencies, while maintaining or improving quality. AHS is learning from the experiences of peer organizations both within Alberta and in other provinces that have high quality health care services and good health outcomes, but more efficient operations. This work focuses on both supply and compensation related costs.

In the medium-term, AHS will continue to achieve business efficiencies and augment this with a focus on clinical efficiency and appropriateness. AHS will learn from best practice experiences within Alberta and other jurisdictions, quality improvement processes, and research-based evidence, in order to identify unwarranted variations in practice (variations that do not support effective patient/resident outcomes). Strategic Clinical Networks will spearhead the development and implementation of clinical pathways to promote effective patient care, effective transitions in care and the best outcomes for our patients and residents. This work will contribute to reducing adverse events or complications, reducing readmissions, and coordinating care.

In the longer-term, AHS will continue work already underway to promote population health and wellness for all residents of Alberta. Whether it is health promotion, disease prevention or effective self-management of chronic conditions, AHS' focus is to support health and wellness for all Albertans. AHS will also implement a provincial Clinical Information System that will integrate existing technologies and help standardize data to support the flow of information across the health system, allowing for better patient outcomes and improved access to clinical data for analysis and research.

Priority Strategic Risks

AHS has an Enterprise Risk Management (ERM) program that actively monitors and manages risks that may impact the achievement of its strategic directions. Priority strategic risks for AHS are:

- Patient Safety (adverse events)
- Appropriateness of Care (patient transitions and navigation)
- Patient Experience (patient satisfaction)
- Financial Sustainability
- Business Continuity Management (emergency / disaster management)

Mitigation plans have been developed for each risk to guide management activities.

CONSOLIDATED FINANCIAL STATEMENTS

March 31, 2016

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MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL REPORTING

The accompanying consolidated financial statements for the year ended March 31, 2016 are the responsibility of management and have been reviewed and approved by senior management. The consolidated financial statements were prepared in accordance with Canadian Public Sector Accounting Standards and the financial directives issued by Alberta Health, and of necessity include some amounts based on estimates and judgment.

To discharge its responsibility for the integrity and objectivity of financial reporting, management maintains systems of financial management and internal control which give consideration to costs, benefits and risks that are designed to:

- provide reasonable assurance that transactions are properly authorized, executed in accordance with prescribed legislation and regulations, and properly recorded so as to maintain accountability of public money;
- safeguard the assets and properties of the Province under Alberta Health Services' administration

Alberta Health Services carries out its responsibility for the consolidated financial statements through the Audit & Risk Committee (the Committee). The Committee meets with management and the Auditor General of Alberta to review financial matters, and recommends the consolidated financial statements to the Alberta Health Services Board for approval upon finalization of the audit. The Auditor General of Alberta has free access to the Committee.

The Auditor General of Alberta provides an independent audit of the consolidated financial statements. His examination is conducted in accordance with Canadian Generally Accepted Auditing Standards and includes tests and procedures which allow him to report on the fairness of the consolidated financial statements prepared by management.

[Original Signed By]

Dr. Verna Yiu, MD, FRCPC
President and Chief Executive Officer
Alberta Health Services

[Original Signed By]

Deborah Rhodes, CPA, CA
Vice President Corporate Services and Chief Financial Officer
Alberta Health Services

June 3, 2016

AUDITOR GENERAL *Alberta*

Independent Auditor's Report

To the Minister of Health

Report on the Consolidated Financial Statements

I have audited the accompanying consolidated financial statements of Alberta Health Services, which comprise the consolidated statement of financial position as at March 31, 2016, the consolidated statements of operations, remeasurement gains and losses, change in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on these consolidated financial statements based on my audit. I conducted my audit in accordance with Canadian generally accepted auditing standards. Those standards require that I comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

I believe that the audit evidence I have obtained in my audit is sufficient and appropriate to provide a basis for my audit opinion.

Opinion

In my opinion, the consolidated financial statements present fairly, in all material respects, the financial position of Alberta Health Services as at March 31, 2016, and the results of its operations, its remeasurement gains and losses, its changes in net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

[Original signed by Merwan N. Saher FCPA, FCA]

Auditor General

June 3, 2016

Edmonton, Alberta

CONSOLIDATED STATEMENT OF OPERATIONS
YEAR ENDED MARCH 31

	2016		2015
	Budget (Note 3)	Actual	Actual (Schedule 3)
Revenue:			
Alberta Health transfers			
Base operating	$ 11,330,000	$ 11,329,851	$ 10,851,204
Other operating	1,110,000	1,064,739	1,378,438
Capital	84,000	84,716	92,907
Other government transfers (Note 4)	416,000	416,554	420,599
Fees and charges	507,000	491,487	472,389
Ancillary operations	132,000	133,220	133,118
Donations, fundraising, and non-government contributions (Note 5)	166,000	163,221	167,290
Investment and other income (Note 6)	208,000	267,931	308,308
TOTAL REVENUE	**13,953,000**	**13,951,719**	**13,824,253**
Expenses:			
Inpatient acute nursing services	3,157,000	3,268,711	3,213,808
Emergency and other outpatient services	1,619,000	1,635,271	1,586,065
Facility-based continuing care services	1,047,000	1,035,366	1,005,796
Ambulance services	468,000	478,068	475,430
Community-based care	1,222,000	1,205,926	1,138,026
Home care	542,000	567,657	535,617
Diagnostic and therapeutic services	2,248,000	2,274,271	2,234,862
Promotion, prevention, and protection services	379,000	363,149	360,911
Research and education	240,000	224,316	235,411
Administration (Note 7)	454,000	426,264	448,030
Information technology	566,000	565,158	568,861
Support services (Note 8)	2,011,000	2,055,706	2,023,940
TOTAL EXPENSES (Schedule 1)	**13,953,000**	**14,099,863**	**13,826,757**
ANNUAL OPERATING SURPLUS (DEFICIT)	-	**(148,144)**	**(2,504)**
Endowment contributions and reinvested income	-	3,585	3,585
ANNUAL SURPLUS (DEFICIT)	$ -	$ **(144,559)**	$ **1,081**
Accumulated surplus, beginning of year		1,303,682	1,302,601
Accumulated surplus, end of year (Note 19)		$ **1,159,123**	$ **1,303,682**

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION AS AT MARCH 31		
	2016 Actual	2015 Actual (Schedule 3)
Financial Assets:		
Cash	$ 79,867	$ 331,847
Portfolio investments (Note 10)	2,187,506	2,173,493
Accounts receivable (Note 11)	393,493	313,972
Other assets	11,826	12,179
	2,672,692	2,831,491
Liabilities:		
Accounts payable and accrued liabilities (Note 12)	1,236,312	1,273,899
Employee future benefits (Note 13)	620,687	594,603
Unexpended deferred operating revenue (Note 14)	429,515	491,254
Unexpended deferred capital revenue (Note 15)	148,319	178,078
Debt (Note 17)	326,909	321,831
	2,761,742	2,859,665
NET DEBT	**(89,050)**	**(28,174)**
Non-Financial Assets:		
Tangible capital assets (Note 18)	7,573,071	7,511,137
Inventories for consumption	94,439	96,583
Prepaid expenses	116,117	126,610
	7,783,627	7,734,330
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	7,694,577	7,706,156
Expended deferred capital revenue (Note 16)	6,530,432	6,363,699
NET ASSETS	**1,164,145**	**1,342,457**
Net Assets is comprised of:		
Accumulated surplus (Note 19)	1,159,123	1,303,682
Accumulated remeasurement gains and losses	5,022	38,775
	$ 1,164,145	**$ 1,342,457**

Contractual Obligations and Contingent Liabilities (Note 20)

The accompanying notes and schedules are part of these consolidated financial statements.

Approved by the Board of Directors:

[Original Signed By]

Linda Hughes
Board Chair

[Original Signed By]

David Carpenter, FCPA, FCA
Audit & Risk Committee Chair

CONSOLIDATED STATEMENT OF CHANGE IN NET DEBT
YEAR ENDED MARCH 31

	2016		2015
	Budget (Note 3)	Actual	Actual
Annual surplus (deficit)	$ -	$ (144,559)	$ 1,081
Effect of changes in tangible capital assets:			
Acquisition of tangible capital assets (Note 18)	(940,000)	(650,785)	(642,235)
Amortization, disposals and write-downs of tangible capital assets (Note 18)	618,000	588,851	633,593
Effect of other changes:			
Net increase in expended deferred capital revenue	290,000	166,733	87,230
Net (increase) decrease in inventories for consumption	(1,000)	2,144	1,669
Net (increase) decrease in prepaid expense	10,000	10,493	(20,211)
Net (increase) decrease in remeasurement gains (losses)	(16,000)	(33,753)	13,929
(Increase) decrease in net debt	**(39,000)**	**(60,876)**	**75,056**
Net debt, beginning of year	(28,000)	(28,174)	(103,230)
Net debt, end of year	**$ (67,000)**	**$ (89,050)**	**$ (28,174)**

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF REMEASUREMENT GAINS AND LOSSES YEAR ENDED MARCH 31	2016 Actual	2015 Actual
Accumulated remeasurement gains, beginning of year	$ 38,775	$ 24,846
Unrestricted unrealized net gains (losses) on portfolio investments	(18,705)	43,724
Amounts reclassified to the Consolidated Statement of Operations related to portfolio investments	(15,048)	(29,795)
Net remeasurement gains (losses) for the year	**(33,753)**	**13,929**
Accumulated remeasurement gains, end of year (Note 10)	**$ 5,022**	**$ 38,775**

The accompanying notes and schedules are part of these consolidated financial statements.

CONSOLIDATED STATEMENT OF CASH FLOWS
YEAR ENDED MARCH 31

	2016 Actual	2015 Actual (Schedule 3)
Operating transactions:		
Annual surplus (deficit)	$ (144,559)	$ 1,081
Non-cash items:		
Amortization, disposals, and write-downs	588,851	633,593
Recognition of expended deferred capital revenue	(394,294)	(427,506)
Decrease (increase) in:		
Accounts receivable related to operating transactions	(49,250)	72,533
Inventories for consumption	2,144	1,669
Other assets	353	(575)
Prepaid expenses	10,493	(20,211)
Increase (decrease) in:		
Accounts payable and accrued liabilities related to operating transactions	(39,564)	85,372
Employee future benefits	26,084	40,071
Deferred revenue related to operating transactions	(80,367)	(74,491)
Cash provided by (applied to) operating transactions	(80,109)	311,536
Capital transactions:		
Acquisition of tangible capital assets	(233,213)	(229,734)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	(6,434)	(31,797)
Cash provided by (applied to) capital transactions	(239,647)	(261,531)
Investing transactions:		
Purchase of portfolio investments	(4,230,911)	(4,203,953)
Proceeds on disposals of portfolio investments	4,133,948	4,291,898
Cash provided by (applied to) investing transactions	(96,963)	87,945
Financing transactions:		
Restricted capital revenue received	164,359	96,977
Restricted capital revenue returned	(4,698)	(14,119)
Proceeds from debt	20,300	5,000
Principal payments on debt	(15,222)	(14,535)
Cash provided by (applied to) financing transactions	164,739	73,323
Net increase (decrease) in cash	**(251,980)**	**211,273**
Cash, beginning of year	331,847	120,574
Cash, end of year	**$ 79,867**	**$ 331,847**

The accompanying notes and schedules are part of these consolidated financial statements.

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
MARCH 31, 2016

Note 1 Authority, Purpose and Operations

Alberta Health Services (AHS) was established under the *Regional Health Authorities Act* (Alberta), effective April 1, 2009, as a result of the amalgamation of 12 formerly separate health entities in Alberta.

Pursuant to Section 5 of the *Regional Health Authorities Act* (Alberta), AHS is responsible in Alberta to:

- promote and protect the health of the population in the health region and work toward the prevention of disease and injury;
- assess on an ongoing basis the health needs of the health region;
- determine priorities in the provision of health services in the health region and allocate resources accordingly;
- ensure that reasonable access to quality health services is provided in and through the health region; and
- promote the provision of health services in a manner that is responsive to the needs of individuals and communities and supports the integration of services and facilities in the health region.

Additionally, AHS is accountable to the Minister of Health (the Minister) for the delivery and operation of the public health system.

The AHS consolidated financial statements include the revenue and expenses associated with its responsibilities. These consolidated financial statements do not reflect the complete costs of provincial health care. For example, the Department of Health is responsible for paying most physician fees. For a complete picture of the costs of provincial healthcare, readers should consult the consolidated financial statements of the Government of Alberta (GOA).

AHS and its contracted health service providers deliver health services at facilities and sites grouped in the following areas: addiction treatment, community mental health, standalone psychiatric facilities, acute care hospitals, sub-acute care in auxiliary hospitals, long-term care, palliative care, supportive living, cancer care, community ambulatory care centres, and urgent care centres.

AHS is exempt from the payment of income taxes under the *Income Tax Act* (Canada).

Note 2 Significant Accounting Policies and Reporting Practices

(a) Basis of Presentation

AHS operates as a Government Not-for-Profit Organization. These consolidated financial statements have been prepared in accordance with Canadian Public Sector Accounting Standards (PSAS) and the financial directives issued by Alberta Health (AH).

These financial statements have been prepared on a consolidated basis and include the following entities:

(i) Controlled Entities

The consolidated financial statements reflect the assets, liabilities, revenues, and expenses of the following entities which are controlled by AHS:

Wholly Owned Subsidiaries:

- Calgary Laboratory Services Ltd. (CLS) - provides medical diagnostic services in Calgary and southern Alberta.
- Capital Care Group Inc. (CCGI) - manages continuing care programs and facilities in the Edmonton area.
- Carewest - manages continuing care programs and facilities in the Calgary area.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

Foundations:

Airdrie Health Foundation
Alberta Cancer Foundation (ACF)
Bassano and District Health Foundation
Bow Island and District Health Foundation
Brooks and District Health Foundation
Calgary Health Trust (CHT)
Canmore and Area Health Care Foundation
Cardston and District Health Foundation
Claresholm and District Health Foundation
Crowsnest Pass Health Foundation
David Thompson Health Trust
Fort Macleod and District Health Foundation
Fort Saskatchewan Community Hospital Foundation
Grande Cache Hospital Foundation
Grimshaw/Berwyn Hospital Foundation
Jasper Health Care Foundation
Lac La Biche Regional Health Foundation *(effective September 2015)*
Lacombe Hospital and Care Centre Foundation
Medicine Hat and District Health Foundation
Mental Health Foundation
North County Health Foundation
Oyen and District Health Care Foundation
Peace River and District Health Foundation
Ponoka and District Health Foundation
Stettler Health Services Foundation
Strathcona Community Hospital Foundation
Tofield and Area Health Services Foundation
Two Hills Health Centre Foundation *(effective December 2014)*
Vermillion and Region Health and Wellness Foundation *(inactive)*
Viking Health Foundation
Vulcan County Health and Wellness Foundation
Windy Slopes Health Foundation

Provincial Health Authorities of Alberta Liability and Property Insurance Plan (LPIP):

AHS consolidates its interest in the LPIP. AHS has the majority of representation on the LPIP's governance board and is therefore considered to control the LPIP. The main purpose of the LPIP is to share the risks of general and professional liability to lessen the impact on any one subscriber.

Other:

Queen Elizabeth II Hospital Child Care Centre

(ii) Government Partnerships

AHS uses the proportionate consolidation method to account for its 50% interest in the Primary Care Network (PCN) government partnerships with physician groups, its 50% interest in the Northern Alberta Clinical Trials Centre (NACTRC) partnership with the University of Alberta, and its 30% interest in the HUTV Limited Partnership (HUTV) with David Chittick Management Ltd., (Note 22).

AHS has joint control with various physician groups over PCNs. AHS entered into local primary care initiative agreements to jointly manage and operate the delivery of primary care services, to achieve the PCN business plan objectives, and to contract and hold property interests required in the delivery of PCN services.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

The following PCNs are included in these consolidated financial statements on a proportionate basis:

Alberta Heartland Primary Care Network
Aspen (Athabasca/Westlock) Primary Care Network
Big Country Primary Care Network
Bonnyville Primary Care Network
Bow Valley Primary Care Network
Calgary Foothills Primary Care Network
Calgary Rural Primary Care Network
Calgary West Central Primary Care Network
Camrose Primary Care Network
Chinook Primary Care Network
Cold Lake Primary Care Network
Drayton Valley Primary Care Network
Edmonton North Primary Care Network
Edmonton Oliver Primary Care Network
Edmonton Southside Primary Care Network
Edmonton West Primary Care Network
Grande Cache Primary Care Network
Grande Prairie Primary Care Network
Highland Primary Care Network
Kalyna Country Primary Care Network
Lakeland (St. Paul/Aspen) Primary Care Network
Leduc Beaumont Devon Primary Care Network
Lloydminster Primary Care Network
McLeod River Primary Care Network
Mosaic Primary Care Network
Northwest Primary Care Network
Palliser Primary Care Network
Peace Region Primary Care Network
Peaks to Prairies Primary Care Network
Provost Primary Care Network
Red Deer Primary Care Network
Rocky Mountain House Primary Care Network
Sexsmith/Spirit River Primary Care Network
Sherwood Park/ Strathcona County Primary Care Network
South Calgary Primary Care Network
St. Albert & Sturgeon Primary Care Network
Wainwright Primary Care Network
West Peace Primary Care Network
WestView Primary Care Network
Wetaskiwin Primary Care Network
Wolf Creek Primary Care Network
Wood Buffalo Primary Care Network

(iii) Other

These consolidated financial statements do not include trusts administered on behalf of others (Note 23).

All inter-entity accounts and transactions between these organizations are eliminated upon consolidation.

Adjustments are made for consolidated entities whose fiscal year-end are different from AHS' fiscal year end. This only consists of LPIP with a fiscal year-end of December 31, 2015.

(b) Revenue Recognition

Revenue is recognized in the period in which the transactions or events that give rise to the revenue as described below occur. All revenue is recorded on an accrual basis, except when the accrual cannot be determined within a reasonable degree of certainty or when estimation is impracticable.

(i) Government Transfers

Transfers from AH, other GOA ministries and agencies, and other government entities are referred to as government transfers.

Government transfers and the associated externally restricted investment income are recorded as deferred revenue if the eligibility criteria for the use of the transfer, or the stipulations together with AHS' actions and communications as to the use of the transfer, create a liability. These transfers are recognized as revenue as the stipulations are met and, when applicable, AHS complies with its communicated use of the transfer.

All other government transfers, without stipulations for the use of the transfer, are recorded as revenue when the transfer is authorized and AHS meets the eligibility criteria.

Deferred revenue consists of unexpended deferred operating revenue, unexpended deferred capital revenue, and expended deferred capital revenue. The term deferred revenue in these consolidated financial statements refers to the components of deferred revenue as described.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(ii) Donations, Fundraising, and Non-Government Contributions

Donations, fundraising, and non-government contributions are received from individuals, corporations, and other not-for-profit organizations. Donations, fundraising, and non-government contributions may be unrestricted or externally restricted for operating or capital purposes.

Unrestricted donations, fundraising, and non-government contributions are recorded as revenue in the year received or in the year the funds are committed to AHS if the amount can be reasonably estimated and collection is reasonably assured.

Externally restricted donations, fundraising, non-government contributions, and realized and unrealized gains and losses for the associated externally restricted investment income are recorded as deferred revenue if the terms for their use, or the terms along with AHS' actions and communications as to their use create a liability. These resources are recognized as revenue as the terms are met and, when applicable, AHS complies with its communicated use.

In-kind donations of services and materials are recorded at fair value when such value can reasonably be determined. While volunteers contribute a significant amount of time each year to assist AHS, the value of their services is not recognized as revenue and expenses in the consolidated financial statements because fair value cannot be reasonably determined.

(iii) Transfers and Donations of or for Land

AHS records transfers and donations to buy land as a liability when received and recognizes as revenue when AHS buys the land. AHS recognizes in-kind contributions of land as revenue at the fair value of the land when a fair value can be reasonably determined. When AHS cannot determine the fair value, it records such in-kind contributions at nominal value.

(iv) Endowments

Endowments are included in Financial Assets and Accumulated Surplus in the Consolidated Statement of Financial Position. Endowments contributions and associated investment income are recognized in the Consolidated Statement of Operations in the period in which they are received. Donors have placed restrictions on their contribution to the endowment funds.

All unrealized gains and losses attributable to endowments are recognized as an increase or decrease in deferred revenue. Realized gains and losses on portfolio investments attributable to endowments are recognized as increases or decreases in deferred revenue when received or receivable and are subsequently recognized in the Consolidated Statement of Operations when the terms of use are met, as stipulated by the donors.

(v) Fees and Charges, Ancillary Operations, and Other Income

Fees and charges, ancillary operations, and other income are recognized in the period that goods are delivered or services are provided. Amounts received for which goods or services have not been provided by year end is recorded as deferred revenue.

(vi) Investment Income

Investment income includes dividend and interest income, and realized gains or losses on the sale of portfolio investments. Unrealized gains and losses on portfolio investments that are not from restricted transfers or donations are recognized in the Consolidated Statement of Remeasurement Gains and Losses until the related investments are sold. Once realized, these gains or losses are recognized in the Consolidated Statement of Operations. Investment income and unrealized gains and losses that are from restricted transfers or donations are allocated to the respective transfer or donation balances according to the provisions within the individual agreements.

(c) Expenses

Expenses are reported on an accrual basis. The cost of all goods consumed and services received during the year are expensed. Interest expense includes debt servicing costs.

Expenses include grants and transfers under shared cost agreements. Grants and transfers are recorded as expenses when the transfer is authorized and eligibility criteria have been met by the recipient.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(d) Financial Instruments

All of AHS' financial assets and liabilities are initially recorded at their fair value. The following table identifies AHS' financial assets and liabilities and identifies how they are subsequently measured:

Financial Assets and Liabilities	Subsequent Measurement and Recognition
Cash and portfolio investments	Measured at fair value with changes in fair values recognized in the Consolidated Statement of Remeasurement Gains and Losses, or deferred revenue until realized at which time the cumulative changes in fair value are recognized in the Consolidated Statement of Operations.
Accounts receivable, accounts payable and accrued liabilities and debt	Measured at cost.

PSAS requires portfolio investments in equity instruments quoted in an active market to be recorded under the fair value category and AHS may choose to record other financial assets under the fair value category if there is an investment strategy to evaluate the performance of a group of these financial assets on a fair value basis. AHS has elected to record its money market securities, fixed income securities, and certain other equity investments at fair value. The three levels of information that may be used to measure fair value are:

- Level 1 – Unadjusted quoted market prices in active markets for identical assets or liabilities;
- Level 2 – Observable or corroborated inputs, other than level 1, such as quoted prices for similar assets or liabilities in inactive markets or market data for substantially the full term of the assets or liabilities; and
- Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets and liabilities.

AHS measures and recognizes embedded derivatives separately from the host contract when the economic characteristics and risk of the embedded derivative are not closely related to those of the host contract, when it meets the definition of a derivative and, when the entire contract is not measured at fair value. Embedded derivatives are recorded at fair value. For the year ended March 31, 2016, AHS has no embedded derivatives that require separation from the host contract.

Derivatives are recorded at fair value in the Consolidated Statement of Financial Position. Derivatives with a positive or negative fair value are recognized as increases or decreases to investments. Unrealized gains and losses from changes in the fair value of derivatives are recognized in the Consolidated Statement of Remeasurement Gains and Losses.

All financial assets are assessed for impairment on an annual basis. When a decline is determined to be other than temporary, the amount of the loss is reported as a realized loss on the Consolidated Statement of Operations.

Transaction costs associated with the acquisition and disposal of portfolio investments are expensed as incurred. Investment management fees are expensed as incurred. The purchase and sale of portfolio investments are accounted for using trade date accounting.

(e) Cash

Cash is comprised of cash on hand and demand deposits.

(f) Inventories For Consumption

Inventories for consumption or distribution at no charge are valued at lower of cost (defined as moving average cost) and replacement cost.

(g) Tangible Capital Assets

Tangible capital assets and work in progress are recorded at cost, which includes amounts that are directly related to the acquisition, design, construction, development, improvement, or betterment of the assets. Cost includes overhead directly attributable to construction and development as well as interest costs that are directly attributable to the acquisition or construction of the asset. Contributed tangible capital assets and work in progress acquired from other government organizations and other entities are recorded at their fair value on the date of donation. When AHS cannot determine the fair value, in-kind contributions are recorded at a nominal value. Costs incurred by Alberta Infrastructure (AI) to build tangible capital assets on behalf of AHS are recorded by AHS as work in progress and expended deferred capital revenue as AI incurs costs.

Works of art, historical treasures, and collections are expensed when purchased or contributed and not recognized in tangible capital assets.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

The cost less residual value of tangible capital assets, excluding land, is amortized over their estimated useful lives on a straight-line basis as follows:

	Useful Life
Facilities and improvements	10-40 years
Equipment	3-20 years
Information systems	3-5 years
Leased vehicles, facilities and improvements	Term of lease
Building service equipment	5-40 years
Land improvements	5-40 years

Work in progress, which includes facility and improvement projects and development of information systems, is not amortized until after a project is substantially complete and the assets are put into service.

Leases transferring substantially all benefits and risks of tangible capital asset ownership are classified as capital leases and reported as tangible capital asset acquisitions. The capital lease obligations associated with these capital leases are recorded at the present value of the minimum lease payments excluding executory costs (e.g. insurance, maintenance costs, etc.). The discount rate used to determine the present value of the lease payments is the lower of AHS' rate for incremental borrowing or the interest rate implicit in the lease.

Tangible capital assets are written down when conditions indicate that they no longer contribute to AHS' ability to provide goods and services, or when the value of future economic benefits associated with the tangible capital assets are less than their net book value. The net write-downs are accounted for as expenses in the Consolidated Statement of Operations. Write-downs are not reversed.

(h) Employee Future Benefits

(i) Registered Benefit Pension Plans

AHS participates in the following registered defined benefit pension plans: the Local Authorities Pension Plan (LAPP) and the Management Employees Pension Plan (MEPP). These multi-employer public sector defined benefit plans provide pensions for participants for each year of pensionable service based on the average salary of the highest five consecutive years, up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE), over the same five consecutive year period. Benefits for post-1991 service payable under these plans are limited by the *Income Tax Act* (Canada). The President of Alberta Treasury Board and Minister of Finance is the legal trustee and administrator of the plans. The Department of Treasury Board and Finance accounts for its share of obligations for these pension plans relating to former and current employees of all of the organizations included in the GOA consolidated reporting entity on a defined benefit basis. As a participating government organization, AHS accounts for these plans on a defined contribution basis. Accordingly, the pension expense recorded for these plans in these consolidated financial statements is comprised of the employer contributions that AHS is required to pay for its employees during the fiscal year, which are calculated based on actuarially pre-determined amounts that are expected to provide the plan's future benefits.

(ii) Other Defined Contribution Pension Plans

AHS sponsors Group Registered Retirement Savings Plans (GRRSPs) for certain employee groups. Under the GRRSPs, AHS matches a certain percentage of any contribution made by plan participants up to certain limits. AHS also sponsors a defined contribution pension plan for certain employee groups where the employee and employer each contribute specified percentages of pensionable earnings.

(iii) Supplemental Executive Retirement Plans (SERPs)

AHS sponsors SERPs, which are funded, and has three Retirement Compensation Arrangements (RCA) for these plans. The SERPs cover certain employees and supplement the benefits under AHS' registered plans that are limited by the Income Tax Act (Canada). Each plan was closed to new entrants effective April 1, 2009. SERPs provide future pension benefits to participants based on years of service and earnings.

Due to Income Tax Act (Canada) requirements, the SERPs are subject to the RCA rules; therefore approximately half the assets are held in a non-interest bearing Refundable Tax Account with the Canada Revenue Agency. The remaining assets of the SERPs are invested in a combination of Canadian equities and Canadian fixed income securities.

The obligations and costs of these benefits are determined annually through an actuarial valuation as at March 31 using the projected benefit method pro-rated on service. AHS uses a discount rate based on plan asset earnings to calculate the accrued benefit obligation.

The net retirement benefit cost of SERPs reported in these consolidated financial statements is comprised of the retirement benefits expense and the retirement benefits interest expense. Costs shown reflect the total estimated cost to provide annual pension income over an actuarially determined post employment period. The key components of retirement benefits expense include the current period benefit cost, cost of any plan amendments including related net actuarial gains or losses incurred in the period, gains and losses from any plan settlements or curtailments incurred in the period, and amortization of actuarial gains and losses. Retirement benefit costs are not cash payments in the period but are the period expense for rights to future compensation. The retirement benefits interest expense is net of the interest cost on the accrued benefit obligation and the expected return on plan assets.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

The actuarial gains and losses that arise are accounted for in accordance with PSAS whereby AHS amortizes actuarial gains and losses from the liability or asset over the average remaining service life of the related employee group.

Prior period service costs arising from plan amendments are recognized in the period of the plan amendment. When an employee's accrued benefit obligation is fully discharged, all unrecognized amounts associated with that employee are fully recognized in the net retirement benefit cost in the following year.

(iv) Supplemental Pension Plan (SPP)

Subsequent to April 1, 2009, staff eligible for SERP are enrolled in a defined contribution SPP. Similar to the SERP, the SPP supplements the benefits under AHS registered plans that are limited by the *Income Tax Act* (Canada). AHS contributes a certain percentage of an eligible employee's pensionable earnings, in excess of the limits of the *Income Tax Act* (Canada). This plan provides participants with an account balance at retirement based on the contributions made to the plan and investment income earned on the contributions based on investment decisions made by the participant.

(v) Sick Leave Liability

Sick leave benefits accumulate with employees' service and are provided by AHS to certain employee groups of AHS, as defined by employment agreements, to cover illness related absences that are outside of short-term and long-term disability coverage. Benefit amounts are determined and accumulate with reference to employees' final earnings at the time they are paid out. The cost of the accumulating non-vesting sick leave benefits is expensed as the benefits are earned.

AHS accrues its liabilities for accumulating non-vesting sick leave benefits but does not record a liability for sick leave benefits that do not accumulate beyond the current reporting period as these are renewed annually.

The accumulating non-vesting sick leave liability is actuarially determined using the projected benefit method prorated on service and management's best estimates of expected discount rate, inflation, rate of compensation increase, termination and retirement rates, and mortality. The liability associated with these benefits is calculated as the present value of expected future payments pro-rated for service.

Any resulting net actuarial gain (loss) is deferred and amortized on a straight-line basis over the expected average remaining service life of the related employee groups.

(vi) Other Benefits

AHS provides its employees with basic life, accidental death and dismemberment, short-term disability, long-term disability, extended health, dental, and vision benefits through benefits carriers. AHS fully accrues its obligations for employee non-pension future benefits.

(i) Liability for Contaminated Sites

Contaminated sites are a result of contamination being introduced into air, soil, water, or sediment of a chemical, organic or radioactive material or live organism that exceeds an environmental standard. The liability is recorded net of any expected recoveries. A liability for remediation of contaminated sites is recognized when all of the following criteria are met:

(i) an environmental standard exists;
(ii) contamination exceeds the environmental standard;
(iii) AHS is directly responsible or accepts responsibility;
(iv) it is expected that future economic benefits will be given up; and
(v) a reasonable estimate of the amount can be made.

(j) Measurement Uncertainty

The consolidated financial statements, by their nature, contain estimates and are subject to measurement uncertainty. Measurement uncertainty exists when there is a variance between the recognized or disclosed amount and another reasonably possible amount. The amount recorded for amortization of tangible capital assets is based on the estimated useful life of the related assets while the recognition of expended deferred capital revenue depends on when the terms for the use of the funding are met and, when applicable, AHS complies with its communicated use of the funding. The amounts recorded for employee future benefits are based on estimated future cash flows. The provision for unpaid claims, allowance for doubtful accounts and accrued liabilities are subject to significant management estimates and assumptions. These estimates and assumptions are reviewed at least annually. Actual results could differ from the estimates determined by management in these consolidated financial statements, and these differences, which may be material, could require adjustment in subsequent reporting periods.

The establishment of the provision for unpaid claims relies on the judgment and opinions of many individuals; historical precedent and trends; prevailing legal, economic, and social and regulatory trends; and expectation as to future developments. The process of determining the provision necessarily involves risks that the actual results will deviate perhaps materially from the best estimates made.

Note 2 Significant Accounting Policies and Reporting Practices (continued)

(k) Internally Restricted Surplus for Future Purposes

Certain amounts, as approved by the AHS Board, are set aside in accumulated surplus for future operating and capital purposes. Transfers to or from internally restricted surplus for future purposes are recorded to the respective reserved surplus when approved.

(l) Changes in Accounting Policy

Adoption of the Net Debt Presentation

The net debt model (with reclassification of comparatives) has been adopted for the presentation of financial statements. Net debt is measured as the difference between AHS' financial assets and liabilities.

The effect of this change has resulted in a change in the presentation of the Consolidated Statement of Financial Position and the inclusion of the Consolidated Statement of Change in Net Debt. The impact of this change on the Consolidated Statement of Financial Position is presented in Schedule 3.

Endowment Contributions and Reinvested Income

Effective April 1, 2015, endowment contributions are recognized in the Consolidated Statement of Operations in the period in which they are received. In prior years, such transactions were recognized as direct increases to endowments on the Consolidated Statement of Financial Position in the period they were received. This change in accounting policy has been applied retroactively with restatement of comparative financial information presented in Schedule 3.

(m) Future Accounting Changes

During fiscal 2015-16 the Public Sector Accounting Board issued the following accounting standards:

- **PS 2200 – Related Parties Disclosures (effective April 1, 2017)**
  PS 2200 defines a related party and establishes disclosures required for related party transactions.
- **PS 3420 – Inter-Entity Transactions (effective April 1, 2017)**
  PS 3420 establishes standards on how to account for and report transactions between public sector entities that comprise a government's reporting entity from both a provider and recipient perspective.
- **PS 3210 – Assets (effective April 1, 2017)**
  PS 3210 provides guidance for applying the definition of assets set out in PS 1000 – Financial Statement Concepts and establishes general disclosure standards for assets.
- **PS 3320 – Contingent Assets (effective April 1, 2017)**
  PS 3320 defines and establishes disclosure standards on contingent assets.
- **PS 3380 – Contractual Rights (effective April 1, 2017)**
  PS 3380 defines and establishes disclosure standards on contractual rights.
- **PS 3430 – Restructuring Transactions (effective April 1, 2018)**
  PS 3430 provides guidance on how to account for and report restructuring transactions by both transferors and recipients of assets and/or liabilities, together with related programs or operating responsibilities.

AHS' management is currently assessing the impact of these new standards on the consolidated financial statements.

Note 3 Budget

The AHS Health Plan and Business Plan 2015-18, which included the 2015-16 annual budget, was approved by the Minister of Health on January 19, 2016. Subsequently, reclassification adjustments were made to the originally approved budget in order to align with the presentation of current year results. Refer to Schedule 3.

Note 4 Other Government Transfers

	2016	2015
Unrestricted operating	$ 60,272	$ 52,760
Restricted operating	88,192	82,578
Restricted capital	268,090	285,261
	$ 416,554	**$ 420,599**

Other government transfers include $409,882 (2015 – $414,442) transferred from the GOA and $6,672 (2015 – $6,157) from the federal government, and exclude amounts from AH as these amounts are separately disclosed on the Consolidated Statement of Operations.

Note 5 Donations, Fundraising, and Non-Government Contributions

	2016	2015
Unrestricted operating	$ 2,622	$ 4,230
Restricted operating	119,111	113,722
Restricted capital	41,488	49,338
	$ 163,221	**$ 167,290**

Note 6 Investment and Other Income

	2016	2015
Investment income	$ 84,900	$ 98,841
Other income:		
External recoveries from the GOA (Note 21)	38,422	43,809
Other revenue	144,609	165,658
	$ 267,931	**$ 308,308**

Other revenue includes revenue related to administrative services provided to other organizations of $10,906 (2015 – $11,978) (Note 7).

Note 7 Administration

	2016	2015
General administration[a]	$ 222,884	$ 228,640
Human resources[b]	91,278	99,325
Finance[c]	61,872	65,187
Communications[d]	12,596	16,492
Direct administration expense incurred by AHS	388,630	409,644
Administration expense of full-spectrum contracted health service providers[e]	37,634	38,386
Total administration expense	**426,264**	**448,030**
Less revenue related to administrative services provided to other organizations (Note 6)	(10,906)	(11,978)
Net administration expense	**$ 415,358**	**$ 436,052**

Net administration expense has been presented to align with the Canadian Institute of Health Information (CIHI) definition. Activities and costs directly supporting clinical activities are not included in administration.

Note 7 Administration (continued)

The following are the direct administration expenses incurred by AHS:

(a) General administration includes senior leaders' expenses, the former Official Administrator expenses, Board expenses, and other administrative functions such as planning and development, privacy, risk management, internal audit, infection control, quality assurance, insurance, patient safety, and legal.

(b) Human resources includes personnel services, staff recruitment and selection, orientation, labour relations, employee health, and employee record keeping.

(c) Finance includes the recording, monitoring, and reporting of the financial and statistical aspects of AHS' planned and actual activities.

(d) Communications includes the receipt and transmission of AHS' communications including electronic communication, visitor information, and mail services. It also includes personnel dedicated to maintenance and repair of communication systems and devices.

In addition, AHS recognizes the following indirect costs as administration expense:

(e) Administration expense of full spectrum contracted health service providers is AHS' estimate of the portion that AHS funds of the general administration, human resources, finance, and communication expenses incurred by service providers with whom AHS contracts for a full spectrum of health services, the largest being Covenant Health.

Note 8 Support Services

	2016	2015
Facilities operations	$ 814,993	$ 831,756
Patient: health records, food services, and transportation	373,682	346,648
Materials management	214,422	180,568
Housekeeping, laundry, and linen	192,341	192,280
Support services expense of full-spectrum contracted health service providers	143,701	150,623
Ancillary operations	110,389	110,889
Fundraising expenses and grants awarded	48,028	38,682
Emergency preparedness services	4,353	3,992
Other	153,797	168,502
	$ 2,055,706	**$ 2,023,940**

Note 9 Financial Instruments

AHS is exposed to a variety of financial risks associated with the entity's financial instruments. These financial risks include market risk, price risk, interest rate risk, foreign currency risk, credit risk, and liquidity risk.

(a) Market Risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises three types of risk: currency risk, interest rate risk, and other price risk.

In order to earn financial returns at an acceptable level of market risk, each of the investment policies have established a targeted asset mix. The AHS Investment Bylaw & Policy has established asset mix ranges of 0% to 100% for cash and money market securities, 0% to 80% for fixed income securities, and 0% to 40% for equities.

The ACF Investment Policy has established an asset mix policy of 0% to 10% for money market securities, 30% to 60% for fixed income securities, and 30% to 70% for equities.

The LPIP Investment Policy has established an asset mix policy of 80% to 87% for cash and fixed income securities, 10% to 15% for equities, and 3% to 5% for real estate.

The CHT Statement of Investment Policies and Goals has established an asset mix policy of 30% to 70% for fixed income securities and 30% to 70% for equities.

Risk is reduced under all of the investment policies through asset class diversification, diversification within each asset class, and portfolio quality constraints.

Note 9 Financial Instruments (continued)

AHS assesses the sensitivity of its portfolio to market risk based on historical volatility of equity and fixed income markets. The volatility is determined using a ten year average based on fixed income and equity market fluctuations and is applied to the total portfolio. Based on the volatility average of 2.69% (2015 – 2.55%) increase or decrease, with all other variables held constant, the increase or decrease in accumulated remeasurement gains and losses would be $45,939 (2015 – $43,297).

(b) Price Risk

Price risk relates to the possibility that equity investments will change in fair value due to future fluctuations in market prices caused by factors specific to an individual equity investment or other factors affecting all equities traded in the market. AHS is exposed to price risk associated with the underlying equity investments held in investment funds. If equity market indices (S&P/TSX, S&P1500 and MSCI ACWI and their sectors) declined by 10%, and all other variables are held constant, the potential loss in fair value to AHS would be approximately 2.11% of total investments (March 31, 2015 – 2.02%).

A 10% change in market value relating to equity securities would have increased or decreased fair value by approximately $46,236 (March 31, 2015 – $43,909).

(c) Interest Rate Risk

Interest rate risk is the risk that the value of a financial instrument might be adversely affected by a change in market interest rates. Changes in market interest rates may have an effect on the cash flows associated with some financial assets and liabilities, known as cash flow risk, and on the fair value of other financial assets or liabilities, known as price risk. AHS manages the interest rate risk exposure of its fixed income investments by management of average duration and laddered maturity dates.

AHS is exposed to interest rate risk through its investments in fixed income securities with both fixed and floating interest rates. AHS has fixed interest rate loans for all debt, thereby mitigating interest rate risk from rate fluctuations over the term of the outstanding debt. The fair value of fixed rate debt fluctuates with changes in market interest rates but the related future cash flows will not change.

In general, investment returns for bonds and mortgage funds are sensitive to changes in the level of interest rates, with longer term interest bearing securities being more sensitive to interest rate changes than shorter-term bonds.

A 1% change in market yield relating to fixed income securities would have increased or decreased fair value by approximately $65,654 (March 31, 2015 – $68,803).

Portfolio investments include fixed income securities, such as bonds and money market securities, and have an average effective yield of 1.61% (2015 – 1.52%) per year maturing between 2016 and 2067. The securities have the following average maturity structure:

	2016	2015
0 – 5 years	76%	74%
6 – 10 years	13%	13%
Over 10 years	11%	13%

	Effective Market Yield			Average Effective Market Yield
Asset Class	< 1 year	1-5 years	> 5 years	
Interest bearing securities	0.69%	1.40%	2.74%	1.61%

(d) Foreign Currency Risk

Foreign currency risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in foreign exchange rates. The fair value of cash and investments denominated in foreign currencies is translated into Canadian dollars using the reporting date exchange rate. AHS is exposed to foreign exchange fluctuations on its cash denominated in foreign currencies. At March 31, 2016, there were no investment balances denominated in foreign currency. Foreign exchange fluctuations on its cash balances are partially mitigated by futures contracts and minimal ending foreign currency cash balances. During the year, the effect of these fluctuations was not significant. AHS has policies which provide management with guidance to mitigate foreign currency risk.

Foreign currency risk is managed by the fact that the investment policies limit non-Canadian equities to a maximum of 10% to 45% of the total investment portfolio, depending on the policy. At March 31, 2016, investments in non-Canadian equities represented 13.40% (March 31, 2015 – 8.60%) of total portfolio investments.

At March 31, 2016, AHS held US dollar forward contracts with ATB Financial to mitigate its exposure to currency fluctuations relating to US dollar accounts payable. As at March 31, 2016, AHS held forward contracts for future settlement of $24,000 (2015 – $24,000). The fair value of these forward contracts as at March 31, 2016 was a loss of $141 (2015 – gain of $2,310) and is included in portfolio investments (Note 10).

Note 9 Financial Instruments (continued)

(e) Credit Risk

Credit risk is the risk of loss arising from the failure of a counterparty to fully honour its financial obligations. The credit quality of financial assets is generally assessed by reference to external credit ratings. Credit risk can also lead to losses when issuers and debtors are downgraded by credit rating agencies. All of the investment policies restrict the types and proportions of eligible investments, thus mitigating AHS' exposure to credit risk.

Accounts receivable primarily consists of amounts receivable from AH, other Alberta government reporting entities, patients, other provinces and territories, Workers' Compensation Board, and the federal government. AHS periodically reviews the collectability of its accounts receivable and establishes an allowance based on its best estimate of potentially uncollectible amounts.

Under the AHS Investment Bylaw, money market securities are limited to a rating of R1 or equivalent or higher, and no more than 10% may be invested in any one issuer. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher and no more than 40% of the total fixed income securities. Investments in debt and equity of any one issuer are limited to 5% of the issuer's total debt and equity. AHS holds unrated mortgage fund investments. Short selling is not permitted.

The ACF Investment Policy limits the overall rating of all fixed income instruments to at least an A rating, and no more than 10% of publicly traded equities may be invested in any one issuer.

The LPIP Investment Policy limits money market securities to a rating of R1 or equivalent or higher, and no more than 10% may be invested in any one issuer, unless guaranteed by the Government of Canada or a Canadian province. Investments in corporate bonds are limited to BBB or equivalent rated bonds or higher. Investments in debt and equity of any one issuer are limited to 10% of total equities. LPIP holds unrated mortgage fund investments.

The CHT Statement of Investment Policies and Goals limits the overall rating of fixed income securities to BBB or equivalent or higher, and no more than 10% of fixed income securities or equities may be invested in any one issuer.

The following table summarizes AHS' investment in debt securities by counterparty credit rating at March 31, 2016.

Credit Rating	2016	2015
Investment Grade (AAA to BBB)	90%	95%
Unrated	10%	5%
	100%	**100%**

(f) Liquidity Risk

Liquidity risk is the risk that AHS will encounter difficulty in meeting obligations associated with financial liabilities that are settled by delivery of cash or another financial asset. Liquidity requirements of AHS are met through funding in advance by AH, income generated from investments, and by investing in liquid assets, such as money market investments, equities, and bonds, traded in an active market that are easily sold and converted to cash.

Note 10 Portfolio Investments

	2016		2015	
	Fair Value	Cost	Fair Value	Cost
Cash held for investments	$ 108,650	$ 108,650	$ 100,031	$ 100,031
Interest bearing securities:				
Money market securities	139,986	139,986	119,474	119,474
Fixed income securities	1,476,511	1,466,168	1,514,894	1,476,687
	1,616,497	**1,606,154**	**1,634,368**	**1,596,161**
Equities:				
Canadian public equities	169,064	155,830	251,346	215,393
Global public equities	293,295	283,265	187,748	145,351
	462,359	**439,095**	**439,094**	**360,744**
Total portfolio investments	**$ 2,187,506**	**$ 2,153,899**	**$ 2,173,493**	**$ 2,056,936**

Included in the portfolio investments is $147,572 (March 31, 2015 – $149,727) that is restricted for use as per the requirements in Sections 99 and 100 of the Insurance Act of Alberta, based on the December 31, 2015 audited financial statements of LPIP. Endowment contributions included in portfolio investments amount to $75,966 (March 31, 2015 – $72,381).

As AHS is made up of multiple entities as described in Note 2(a), portfolio investments are governed independently under multiple investment policies and procedures. The fair value of portfolio investments governed under each investment policy is as follows:

	2016	2015
AHS Investment Bylaw & Policy	$ 1,752,970	$ 1,757,452
ACF Investment Policy	153,158	155,084
LPIP Investment Policy	176,610	160,292
CHT Statement of Investment Policies and Goals	104,768	100,665
	$ 2,187,506	**$ 2,173,493**

Portfolio investments are measured at fair value with the differences between cost and fair value being recorded as a remeasurement gain or loss. The following are the total net remeasurement gains on portfolio investments:

	2016	2015
Accumulated remeasurement gains	$ 5,022	$ 38,775
Restricted unrealized net gains attributable to endowments and portfolio investments related to unexpended deferred operating revenue (Note 14(b))	28,558	58,325
Restricted unrealized net gains attributable to and recorded in:		
Unexpended deferred capital revenue (Note 15(b))	27	10,288
Accounts payable and accrued liabilities (Note 12)	-	9,169
	$ 33,607	**$ 116,557**

Fair Value Hierarchy

	2016		
	Level 1	Level 2	Total
Cash held for investments	$ -	$ 108,650	$ 108,650
Money market securities	-	139,986	139,986
Fixed income securities	-	1,476,511	1,476,511
Equities	361,539	100,820	462,359
March 31, 2016 total amount	**$ 361,539**	**$ 1,825,967**	**$ 2,187,506**
Percent of total	17%	83%	100%

Note 10 Portfolio Investments (continued)

	2015		
	Level 1	Level 2	Total
Cash held for investments	$ -	$ 100,031	$ 100,031
Money market securities	-	119,474	119,474
Fixed income securities	-	1,514,894	1,514,894
Equities	358,251	80,843	439,094
March 31, 2015 total amount	**$ 358,251**	**$ 1,815,242**	**$ 2,173,493**
Percent of total	16%	84%	100%

Note 11 Accounts Receivable

	2016			2015
	Gross Amount	Allowance for Doubtful Accounts	Net Realizable Value	Net Realizable Value
Patient accounts receivable	$ 127,723	$ 29,091	$ 98,632	$ 100,590
AH operating transfers receivable	72,387	-	72,387	44,426
AH capital transfers receivable	-	-	-	1,200
Other operating grants receivable	20,984	-	20,984	28,683
Other capital grants receivable	116,888	-	116,888	85,417
Other accounts receivable	84,710	108	84,602	53,656
	$ 422,692	**$ 29,199**	**$ 393,493**	**$ 313,972**

At March 31, 2015, the total allowance for doubtful accounts was $28,680.

Note 12 Accounts Payable and Accrued Liabilities

	2016	2015
Payroll remittances payable and related accrued liabilities	$ 651,578	$ 680,324
Trade accounts payable and accrued liabilities[a]	371,670	385,667
Provision for unpaid claims[b]	136,378	138,525
Other liabilities	42,496	42,648
Obligation under leased tangible capital assets[c]	34,190	17,566
	1,236,312	**1,264,730**
Unrealized net gains on portfolio investments related to accounts payable and accrued liabilities (Note 10)	-	9,169
	$ 1,236,312	**$ 1,273,899**

(a) Trade Accounts Payable and Accrued Liabilities

Trade accounts payable and accrued liabilities includes payables related to the purchase of tangible capital assets of $57,445 (2015 – $62,923).

(b) Provision for Unpaid Claims

Provision for unpaid claims represents the losses from identified claims likely to be paid and provisions for liabilities incurred but not yet reported.

The provision has been estimated using the discounted value of claim liabilities using a discount rate of 1.95% (2015 – 2.15%) plus a provision for adverse deviation, based on actuarial estimation.

(c) Leased tangible capital assets

The leased tangible capital assets include a site lease with the University of Calgary and a site lease in Peace River, as well as vehicle leases.

The University of Calgary lease expires January 2028. The implicit interest rate payable on this lease is 6.50% (2015 – 6.50%). There are no renewal options, purchase options or escalation clauses related to this leased tangible capital asset.

Note 12 Accounts Payable and Accrued Liabilities (continued)

AHS entered into a lease in Peace River with a term of 20 years and options to renew for two additional terms of 5 years each. The site was occupied in March 2016. The implicit interest rate payable on this lease is 3.4% (2015 – nil).

AHS is contractually committed to future capital lease payments for vehicles until 2020. The implicit interest rate payable on these leases is 1.38% (2015 – 1.60%).

AHS is committed to making payments for leased tangible capital assets as follows:

Year ended March 31	Minimum Lease Payments
2017	$ 5,043
2018	3,522
2019	3,061
2020	2,932
2021	2,694
Thereafter	29,963
	47,215
Less: interest	(13,025)
	$ 34,190

(d) Liability for Contaminated Sites

For the fiscal year ended March 31, 2016, AHS has not identified any liability for contaminated sites (2015 – $nil).

Note 13 Employee Future Benefits

	2016	2015
Accrued vacation pay	$ 514,672	$ 493,845
Accumulating non-vesting sick leave liability[(a)]	106,015	100,758
Registered defined benefit pension plans[(b)(c)]	-	-
	$ 620,687	**$ 594,603**

(a) Accumulating Non-Vesting Sick Leave Liability

Sick leave benefits are paid by AHS; there are no employee contributions and no plan assets.

The AHS sick leave liability is based on an actuarial valuation as at March 31, 2015, and extrapolated for the year ended March 31, 2016.

The following table summarizes the accumulating non-vesting sick leave liability.

Note 13 Employee Future Benefits (continued)

	2016	2015
Change in accrued benefit obligation and funded status		
Accrued benefit obligation and funded status, beginning of year	$ 114,979	$ 97,132
Current service cost	9,939	8,884
Interest cost	3,486	3,871
Benefits paid	(9,435)	(8,243)
Actuarial loss	-	13,335
Accrued benefit obligation and funded status, end of year	**$ 118,969**	**$ 114,979**
Reconciliation to accrued benefit liability		
Funded status – deficit	$ 118,969	$ 114,979
Unamortized net actuarial loss	(12,954)	(14,221)
Accrued benefit liability	**$ 106,015**	**$ 100,758**
Components of expense		
Current service cost	$ 9,939	$ 8,884
Interest cost	3,486	3,871
Amortization of net actuarial loss	1,267	227
Net expense	**$ 14,692**	**$ 12,982**
Assumptions		
Discount rate – beginning of year	2.90%	3.80%
Discount rate – end of year	2.90%	2.90%
Rate of compensation increase per year	2015-2016	2014-2015
	3.21%	0.25%
	2016-2017	2015-2016
	2.43%	3.21%
	Thereafter	Thereafter
	3.25%	3.25%

(b) Local Authorities Pension Plan (LAPP)

(i) AHS Participation in the LAPP

The majority of AHS employees participate in the LAPP. AHS is not responsible for future funding of the plan deficit other than through contribution increases. As AHS is exposed to the risk of contribution rate increases, the following disclosure is provided to explain this risk.

The LAPP provides for a pension of 1.4% for each year of pensionable service based on the average salary of the highest five consecutive years up to the average Canada Pension Plan's Year's Maximum Pensionable Earnings (YMPE), over the same five consecutive year period and 2.0% on the excess, subject to the maximum pension benefit limit allowed under the *Income Tax Act* (Canada). The maximum pensionable service allowable under the plan is 35 years.

The contribution rates were reviewed by the LAPP Board of Trustees in 2015 and are to be reviewed at least once every three years based on a report prepared by LAPP's actuary. AHS and its employees made the following contributions:

Calendar 2015		Calendar 2014	
Employer	Employees	Employer	Employees
$563,4[illegible]	$519,561	$541,683	$500,179
11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess	11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess

AHS contributed $563,424 (2014 – $541,683) of the LAPP's total employer contributions of $1,282,937 from January 1, 2015 to December 31, 2015 (December 31, 2014 – $1,227,346).

Note 13 Employee Future Benefits (continued)

(ii) LAPP Deficit

An actuarial valuation of the LAPP was carried out as at December 31, 2014 by Mercer (Canada) Limited and these results were then extrapolated to December 31, 2015 for use in the LAPP 2015 audited financial statements. LAPP's net assets available for benefits divided by LAPP's pension obligation shows that the LAPP is 97% (2014 – 93%) funded.

	December 31, 2015	December 31, 2014
LAPP net assets available for benefits	$ 34,419,584	$ 30,790,364
LAPP pension obligation	35,343,000	33,245,000
LAPP deficiency	**$ (923,416)**	**$ (2,454,636)**

The 2016 and 2017 LAPP contribution rates are as follows:

Calendar 2017 (estimated)[1]		Calendar 2016	
Employer	Employees	Employer	Employees
11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess	11.39% of pensionable earnings up to the YMPE and 15.84% of the excess	10.39% of pensionable earnings up to the YMPE and 14.84% of the excess

[1] The 2017 LAPP contribution rates are estimates and subject to change.

(c) Management Employees Pension Plan (MEPP)

At December 31, 2015 the MEPP reported a surplus of $299,051 (December 31, 2014 – surplus of $75,805).

(d) Pension Expense

	2016	2015
Local Authorities Pension Plan	$ 570,438	$ 547,676
Defined contribution pension plans and group RRSPs	46,763	45,575
Supplemental Pension Plan	1,882	2,795
Supplemental Executive Retirement Plans[1]	(788)	964
Management Employees Pension Plan	668	691
	$ 618,963	**$ 597,701**

[1] AHS uses the straight line method to amortize actuarial gains and losses over the expected average remaining service life of the plan members. The SERP recovery is due to prior year unamortized net actuarial gains being recognized in 2015-16.

Note 14 Unexpended Deferred Operating Revenue

(a) Unexpended deferred operating revenue represents unspent resources with stipulations or external restrictions related to operating expenditures. Changes in the unexpended deferred operating revenue balance are as follows:

	2016				2015
	AH	Other Government[1]	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 203,727	$ 27,377	$ 260,150	$ 491,254	$ 499,231
Received or receivable during the year, net of repayments	1,012,325	45,744	152,918	1,210,987	1,519,601
Restricted investment income	205	2,167	4,207	6,579	7,340
Transferred from (to) unexpended deferred capital revenue	11,994	40,227	(3,826)	48,395	43,917
Recognized as revenue	(1,064,739)	(88,192)	(119,111)	(1,272,042)	(1,574,738)
Miscellaneous other revenue recognized	(204)	(10)	(25,677)	(25,891)	(26,693)
	163,308	**27,313**	**268,661**	**459,282**	**468,658**
Changes in unrealized net gain attributable to endowments and portfolio investments related to unexpended deferred operating revenue	(10,055)	(2,258)	(17,454)	(29,767)	22,596
Balance, end of year	**$ 153,253**	**$ 25,055**	**$ 251,207**	**$ 429,515**	**$ 491,254**

[1] The balance at March 31, 2016 for other government includes $549 of unexpended deferred operating revenue received from the federal government (March 31, 2015 – $973). The remaining balance in other government all relates to the GOA, see Note 21.

(b) The unexpended deferred operating revenue balance at the end of the year is stipulated or externally restricted for the following purposes:

	2016				2015
	AH	Other Government	Donors and Non-Government	Total	Total[1]
Research and education	$ 18,383	$ 3,889	$ 135,876	$ 158,148	$ 148,504
Primary Care Networks	44,146	-	-	44,146	71,230
Physician revenue and alternate relationship plans	20,715	945	-	21,660	22,576
Addiction and mental health	19,314	16	-	19,330	20,049
Cancer prevention, screening and treatment	17,144	6	1,711	18,861	33,001
Long term care partnerships	-	15,479	-	15,479	13,230
Promotion, prevention and community	10,236	1,437	2,447	14,120	26,467
Emergency and outpatient services	6,756	77	4,200	11,033	8,843
Information technology	5,049	(154)	85	4,980	11,739
Continuing care and seniors health	2,748	-	52	2,800	10,019
Administration and support services	3,437	2,333	61,470	67,240	49,117
Others less than $10,000	5,302	1,025	16,833	23,160	18,154
	153,230	**25,053**	**222,674**	**400,957**	**432,929**
Unrealized net gain attributable to endowments and portfolio investments related to unexpended deferred operating revenue (Note 10)	23	2	28,533	28,558	58,325
	$ 153,253	**$ 25,055**	**$ 251,207**	**$ 429,515**	**$ 491,254**

[1] Certain 2015 amounts have been reclassified to conform to 2016 presentation.

Note 15 Unexpended Deferred Capital Revenue

(a) Unexpended deferred capital revenue represents unspent resources with stipulations or external restrictions related to the purchase of tangible capital assets. Changes in the unexpended deferred capital revenue balance are as follows:

	2016				2015
	AH	Other Government(i)	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 77,866	$ 9,838	$ 90,374	$ 178,078	$ 229,855
Received or receivable during the year	30,787	130,565	33,215	194,567	103,997
Transferred tangible capital assets (Note 18(a))	-	399,927	65	399,992	412,706
Restricted investment income	21	42	-	63	240
Unexpended deferred capital revenue returned	2	(2)	(4,698)	(4,698)	(14,119)
Transfer to expended deferred capital revenue	(32,697)	(489,501)	(38,829)	(561,027)	(514,736)
Transferred (to) from unexpended deferred operating revenue	(11,994)	(40,227)	3,826	(48,395)	(43,917)
	63,985	**10,642**	**83,953**	**158,580**	**174,026**
Changes in unrealized net gain on portfolio investments related to unexpended deferred capital revenue	(6,069)	(1,467)	(2,725)	(10,261)	4,052
Balance, end of year	**$ 57,916**	**$ 9,175**	**$ 81,228**	**$ 148,319**	**$ 178,078**

(i) All balances relate to the GOA, see Note 21.

(b) The unexpended deferred capital revenue balance at the end of the year is stipulated or externally restricted for the following purposes:

	2016	2015
AH		
Information systems less than $10,000	$ 38,741	$ 52,587
Medical Equipment Replacement Upgrade Program	11,367	11,707
Equipment less than $10,000	7,781	7,477
Total AH	**57,889**	**71,771**
Other government		
Facilities and improvements less than $10,000	9,176	8,371
Total other government	**9,176**	**8,371**
Donors and non-government		
Equipment less than $10,000	73,918	86,995
Facilities and improvements less than $10,000	7,309	653
Total donors and non-government	**81,227**	**87,648**
Unrealized net gain on portfolio investments related to unexpended deferred capital revenue (Note 10)	27	10,288
	$ 148,319	**$ 178,078**

Note 16 Expended Deferred Capital Revenue

Expended deferred capital revenue represents external resources spent in the acquisition of tangible capital assets stipulated for use in the provision of services over their useful lives. Changes in the expended deferred capital revenue balance are as follows:

	2016				2015
	AH	Other Government(i)	Donors and Non-Government	Total	Total
Balance, beginning of year	$ 349,831	$ 5,835,000	$ 178,868	$ 6,363,699	$ 6,276,469
Transferred from unexpended deferred capital revenue	32,697	489,501	38,829	561,027	514,736
Less: amounts recognized as revenue	(84,716)	(268,090)	(41,488)	(394,294)	(427,506)
Balance, end of year	**$ 297,812**	**$ 6,056,411**	**$ 176,209**	**$ 6,530,432**	**$ 6,363,699**

(i) All balances relate to the GOA, see Note 21.

Note 17 Debt

	2016	2015
Debentures payable[(a)]:		
Parkade loan #1	$ 34,903	$ 37,469
Parkade loan #2	32,505	34,639
Parkade loan #3	41,432	43,664
Parkade loan #4	154,086	160,585
Parkade loan #5	37,204	38,737
Parkade loan #6	25,300	5,000
Other	1,479	1,737
	$ 326,909	**$ 321,831**

(a) AHS issued debentures to Alberta Capital Financing Authority (ACFA), a related party, to finance the construction of parkades. AHS has pledged revenue derived directly or indirectly from the operations of all parking facilities being built, renovated, owned, and operated by AHS as security for these debentures.

The maturity dates and interest rates for the debentures are as follows:

	Maturity Date	Fixed Interest Rate
Parkade loan #1	September 2026	4.4025%
Parkade loan #2	September 2027	4.3870%
Parkade loan #3	March 2029	4.9150%
Parkade loan #4	September 2031	4.9250%
Parkade loan #5	June 2032	4.2280%
Parkade loan #6	December 2035	3.6090%

(b) As at March 31, 2016, AHS has access to a $220,000 (March 31, 2015 – $220,000) revolving demand facility with a Canadian chartered bank which may be used for operating purposes. Draws on the facility bear interest at the bank's prime rate less 0.50% per annum. As at March 31, 2016, AHS has $nil (March 31, 2015 – $nil) draws against this facility.

AHS also has access to a $33,000 (March 31, 2015 – $33,000) revolving demand letter of credit facility which may be used to secure AHS' obligations to third parties. At March 31, 2016, AHS has $3,664 (March 31, 2015 – $3,100) in a letter of credit outstanding against this facility.

AHS is committed to making payments as follows:

	Debentures Payable, Term/Other Loan and Mortgages Payable
Year ended March 31	Principal Payments
2017	$ 16,824
2018	17,612
2019	18,437
2020	19,300
2021	20,205
Thereafter	234,531
	$ 326,909

During the year, the amount of total interest expensed including leased tangible capital assets was $15,249 (2015 – $16,253).

Note 18 Tangible Capital Assets

Historical cost	2015	Additions[a]	Transfers into (out of) Work in Progress	Disposals and Write-downs[b]	2016
Facilities and improvements	$ 8,287,500	$ -	$ 201,923	$ (813)	$ 8,488,610
Work in progress	834,328	524,033	(272,237)	-	1,086,124
Equipment[c]	2,185,995	104,390	4,985	(115,753)	2,179,617
Information systems	1,349,427	4,420	25,595	(47,581)	1,331,861
Building service equipment	539,452	-	27,834	(25)	567,261
Land[d]	110,069	-	-	-	110,069
Leased facilities and improvements	191,866	17,942	10,129	-	219,937
Land improvements	69,148	-	1,771	-	70,919
	$ 13,567,785	**$ 650,785**	**$ -**	**$ (164,172)**	**$ 14,054,398**

Accumulated amortization	2015	Amortization Expense	Effect of Transfers	Effect of Disposals and Write-downs(b)	2016
Facilities and improvements	$ 2,955,848	$ 224,212	$ -	$ (765)	$ 3,179,295
Work in progress	-	-	-	-	-
Equipment[c]	1,602,510	191,046	-	(115,330)	1,678,226
Information systems	1,000,609	128,444	-	(47,581)	1,081,472
Building service equipment	304,910	27,731	-	(25)	332,616
Land[d]	-	-	-	-	-
Leased facilities and improvements	134,819	14,612	-	-	149,431
Land improvements	57,952	2,335	-	-	60,287
	$ 6,056,648	**$ 588,380**	**$ -**	**$ (163,701)**	**$ 6,481,327**

	Net Book Value	
	2016	2015
Facilities and improvements	$ 5,309,315	$ 5,331,652
Work in progress	1,086,124	834,328
Equipment	501,391	583,485
Information systems	250,389	348,818
Building service equipment	234,645	234,542
Land	110,069	110,069
Leased facilities and improvements	70,506	57,047
Land improvements	10,632	11,196
	$ 7,573,071	**$ 7,511,137**

(a) Transferred Tangible Capital Assets

Additions include total transferred capital assets of $399,992 (2015 – $412,706) consisting of $399,927 from AI (2015 – $412,623) and $65 from other sources (2015 – $83).

(b) Disposals and Write-Downs

Disposals and write-downs include disposals of $164,172 and a write-down at a cost of $nil (2015 – disposals of $66,439 and write-down of a facility at a cost of $450) with an effect to accumulated amortization for disposals of $163,701 and write-downs of $nil (2015 – disposals of $65,385 and write-downs of $146).

(c) Leased Equipment

Equipment includes assets acquired through capital leases at a cost of $15,694 (2015 – $17,037) with accumulated amortization of $11,859 (March 31, 2015 – $12,294). For the year ended March 31, 2016, leased equipment included a net decrease of $362 related to vehicle capital leases (2015 – net decrease of $205).

Note 18 Tangible Capital Assets (continued)

(d) Leased Land

Land at the following sites has been leased to AHS at nominal values:

Site	Leased from	Lease expiry
Cross Cancer Institute Parkade	University of Alberta	2019
Evansburg Community Health Centre	Yellowhead County	2031
Myrnam Land	Eagle Hill Foundation	2038
Two Hills Helipad	Stella Stefiuk	2041
McConnell Place North	City of Edmonton	2044
Northeast Community Health Centre	City of Edmonton	2047
Foothills Medical Centre Parkade	University of Calgary	2054
Alberta Children's Hospital	University of Calgary	2103

Note 19 Accumulated Surplus

Accumulated surplus is comprised of the following:

	2016					2015
	Unrestricted Surplus[a]	Internally Restricted Surplus for Future Purposes[b]	Invested in Tangible Capital Assets[c]	Endowments[d]	Total	Total
Balance, beginning of year	$ 272,317	$ 154,900	$ 804,084	$ 72,381	$ 1,303,682	$ 1,302,601
Annual surplus (deficit)	(144,559)	-	-	-	(144,559)	1,081
Tangible capital assets purchased with internal funds	(50,665)	-	50,665	-	-	-
Amortization of internally funded tangible capital assets	194,557	-	(194,557)	-	-	-
Repayment of debt used to fund tangible capital assets	(15,222)	-	15,222	-	-	-
Payments on capital lease obligations	(957)	-	957	-	-	-
Net repayment of life lease deposits	(56)	-	56	-	-	-
Transfer of internally restricted surplus for future purposes	(126,350)	126,350	-	-	-	-
Transfer of endowment contributions	(3,585)	-	-	3,585	-	-
Balance, end of year	**$ 125,480**	**$ 281,250**	**$ 676,427**	**$ 75,966**	**$ 1,159,123**	**$ 1,303,682**

(a) Unrestricted Surplus

Unrestricted surplus represents the portion of accumulated surplus that has not already been internally restricted for future purposes, invested in tangible capital assets, or endowments.

Note 19 Accumulated Surplus (continued)

(b) Internally Restricted Surplus for Future Purposes

The Board has approved the restriction of accumulated surplus for future purposes as follows:

	2016	2015
Future capital purposes [(i)]	$ 102,141	$ 10,000
Parkade infrastructure [(ii)]	73,488	60,920
Insurance equity requirements [(iii)]	41,431	20,012
Provincial Clinical Information Systems initiative [(iv)]	30,158	32,000
Specific local initiatives [(v)]	17,046	15,205
Cancer research [(vi)]	14,935	16,079
Retail food services infrastructure [(vii)]	2,051	684
Internally restricted surplus for future purposes	**$ 281,250**	**$ 154,900**

(i) Restriction of unrestricted surplus related to future capital purposes.
(ii) Restriction of parking services (ancillary operation) surplus to establish parking infrastructure for future major maintenance, upgrades, and construction.
(iii) Restriction of unrestricted surplus related to equity of the LPIP.
(iv) Restriction of unrestricted surplus related to fund the Provincial Clinical Information Systems Initiative.
(v) Restriction of unrestricted surplus for specific local initiatives as a result of local fundraising.
(vi) Restriction of unrestricted surplus to fund cancer research.
(vii) Restriction of retail food services (ancillary operation) surplus to assist with future upgrades, maintenance, equipment, and construction costs for retail food service operations.

(c) Invested in Tangible Capital Assets

The restriction of accumulated surplus is equal to the net book value of internally funded tangible capital assets as these amounts are not available for any other purpose.

(d) Endowments

Endowments represent the portion of accumulated surplus that is restricted and must be maintained in perpetuity.

Note 20 Contractual Obligations and Contingent Liabilities

Contractual obligations are AHS' obligations to others that will become liabilities in the future when the terms of current or existing contracts or agreements are met.

(a) Leases

AHS is contractually committed to future operating lease payments for premises as follows:

Year ended March 31	Total Lease Payments
2017	$ 55,678
2018	43,842
2019	33,122
2020	26,248
2021	19,977
Thereafter	62,641
	$ 241,508

(b) Contingent Liabilities

AHS is subject to legal claims during its normal course of business. AHS records a liability when the assessment of a claim indicates that a future event is likely to confirm that an asset had been impaired or a liability incurred at the date of the financial statements and the amount of the contingent loss can be reasonably estimated.

Accruals have been made in specific instances where it is likely that losses will be incurred based on a reasonable estimate. As at March 31, 2016, accruals have been recorded as part of the provision for unpaid claims (Note 12). Included in this accrual are claims in which AHS has been jointly named with the Minister. The accrual provided for these claims under the provision for unpaid claims represents AHS' portion of the liability.

Note 20 Contractual Obligations and Contingent Liabilities (continued)

AHS has been named in 176 legal claims (2015 – 182 claims) related to conditions in existence at March 31, 2016 where the occurrence of a future event confirming a contingent loss is not reasonably determinable. Of these, 162 claims have $240,665 in specified amounts and 14 have no specified amounts (2015 – 160 claims with $283,332 of specified claims and 22 claims with no specified amounts). The resolution of indeterminable claims may result in a liability, if any, that may be different than the claimed amount.

AHS has been named as a co-defendant, along with the GOA, in a certified Class Action (the Claim) arising from increases to long-term accommodation charges implemented by Alberta Government regulations enacted on and after August 1, 2003, and paid by residents of long-term care facilities. The amount of the Claim has not yet been specified.

Note 21 Related Parties

Transactions with the following related parties are considered to be undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length. Amounts due to or from the related parties and the recorded amounts of the transactions are included within these consolidated financial statements, unless otherwise stated.

The Minister controls AHS through the appointment of the AHS Board by appointing all its members. The viability of AHS' operations depends on transfers from the Ministry. Transactions between AHS and AH are reported and disclosed in the Consolidated Statement of Operations, the Consolidated Statement of Financial Position, and the Notes to the Consolidated Financial Statements, and are therefore excluded from the table below.

Related parties also include key management personnel of AHS. Related party transactions with key management personnel primarily consist of compensation related payments to employees and senior management and are considered to be undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length. No other material related party transactions were identified for the year ended March 31, 2016.

AHS shares a common relationship and is considered to be a related party with those entities consolidated or included on a modified equity basis in the GOA consolidated financial statements. Transactions between AHS and the other ministries that are undertaken on similar terms and conditions to those adopted if the entities were dealing at arm's length are recorded at their exchange amount as follows:

	Revenue[i]		Expenses	
	2016	2015	2016	2015
Ministry of Advanced Education[ii]	$ 59,868	$ 61,789	$ 137,586	$ 131,866
Ministry of Infrastructure[iii]	340,028	339,484	24,796	24,501
Other ministries[iv]	49,096	56,978	29,814	34,091
Total for the year	**$ 448,992**	**$ 458,251**	**$ 192,196**	**$ 190,458**

	Receivable from		Payable to	
	2016	2015	2016	2015
Ministry of Advanced Education [ii]	$ 11,203	$ 8,014	$ 19,009	$ 18,204
Ministry of Infrastructure [iii]	49,688	9,370	-	88
Other ministries [iv]	11,318	13,764	329,757	325,010
Balance, end of year	**$ 72,209**	**$ 31,148**	**$ 348,766**	**$ 343,302**

(i) Revenues with GOA ministries include other government transfers of $409,882 (2015 – $414,442), (Note 4), and other income of $38,422 (2015 – $43,809), (Note 6), and fees and charges of $688 (2015 – $nil).

(ii) Most of AHS transactions with the Ministry of Advanced Education relate to initiatives with the University of Alberta and the University of Calgary. These initiatives include teaching, research, and program delivery. A number of physicians are employed by either AHS or the universities but perform services for both. Due to proximity of locations, some initiatives result in sharing physical space and support services. The revenue and expense transactions are a result of grants provided from one to the other and recoveries of shared costs.

(iii) The transactions with the Ministry of Infrastructure relate to the construction and funding of tangible capital assets. These transactions include operating transfers of $47,634 (2015 – $31,093) and capital transfers recognized of $268,090 (2015 – $285,261) relating to tangible capital assets with stipulations or external restrictions to utilize over their remaining useful lives (Note 4). AHS has also recorded an in-kind transfer and expense of $24,304 (2015 – $23,130) for space that is provided by AI rent free. Transactions with AI also include the transfer of non-cash work-in-progress of $399,927 (2015 – $412,623) included in total amounts disclosed in Note 18(a).

(iv) The payable transactions with other ministries include the debt payable to ACFA (Note 17(a)).

At March 31, 2016, AHS has recorded deferred revenue from other ministries within the GOA, excluding AH, of $24,506 (March 31, 2015 – $26,404) related to unexpended deferred operating revenue (Note 14), $9,175 (March 31, 2015 – $9,838) related to unexpended deferred capital revenue (Note 15) and $6,056,411 (March 31, 2015 – $5,835,000) related to expended deferred capital revenue (Note 16).

Note 21 Related Parties (continued)

Outstanding contingencies in which AHS has been jointly named with other government entities within the GOA are disclosed in Note 20.

Note 22 Government Partnerships

The following is 100% of the financial position and results of operations for AHS' government partnerships with PCNs, NACTRC, and HUTV.

	2016	2015
Financial assets	$ 122,784	$ 160,437
Liabilities	122,784	160,437
Accumulated surplus	$ -	$ -
Total revenue	$ 229,955	$ 201,229
Total expenses	229,955	201,229
Annual surplus	$ -	$ -

AHS has proportionately consolidated 50% of the results of the PCNs and NACTRC and 30% of HUTV.

As required by AH, PCNs can only use accumulated surpluses based on approved surplus utilization; therefore, AHS' proportionate share of these surpluses has been recorded by AHS as deferred revenue.

Note 23 Trusts under Administration

(a) Health Benefit Trust of Alberta (HBTA)

AHS is one of more than 30 participants in the HBTA and has a majority of representation on the HBTA governance board. The HBTA is a formal health and welfare trust established under a Trust Agreement effective January 1, 2000. The HBTA provides health and other related employee benefits pursuant to the authorizing Trust Agreement.

Under the terms of the Trust Agreement, no participating employer or eligible employee shall have any right to any surplus or assets of the Trust nor shall they be responsible for any deficits or liabilities of the Trust.

The HBTA maintains various reserves to adequately provide for all current obligations and reported fund balances of $97,502 as at December 31, 2015 (December 31, 2014 – $116,453). AHS has included in prepaid expenses $71,664 (March 31, 2015 – $85,593) as a share of the HBTA's fund balances representing in substance a prepayment of future premiums. These consolidated financial statements do not include the HBTA other than the premiums paid by AHS. For the period January 1 to December 31, 2015 AHS paid premiums of $311,307 (2014 – $290,440).

(b) Other Trust Funds

AHS receives funds in trust for research and development, education, and other programs. These amounts are held and administered on behalf of others in accordance with the terms and conditions embodied in the relevant agreements with no unilateral power to change the conditions set out in the trust indenture (or agreement) and therefore are not reported in these consolidated financial statements. As at March 31, 2016, the balance of funds held in trust by AHS for research and development is $3,762 (March 31, 2015 – $6,425).

AHS receives funds in trust from continuing care residents for personal expenses. As at March 31, 2016, the balance of these funds is $1,780 (March 31, 2015 – $2,055). These amounts are not included in the consolidated financial statements.

Note 24 Subsequent Events

In early May, wildfires seriously affected the City of Fort McMurray and parts of the Regional Municipality of Wood Buffalo. In response, AHS evacuated its facilities. Preparation for re-entry is underway including restoring AHS health care facilities for service. AHS did not sustain significant structural damage to its facilities as a result of the fire. AHS is currently working with its insurers to assess the financial impact on AHS. This financial impact cannot be estimated at this time.

Note 25 Approval of Consolidated Financial Statements

The consolidated financial statements were approved by the AHS Board on June 3, 2016.

SCHEDULE 1 – CONSOLIDATED SCHEDULE OF EXPENSES BY OBJECT
YEAR ENDED MARCH 31

	2016		2015
	Budget (Note 3)	Actual	Actual (Schedule 3)
Salaries and benefits (Schedule 2)	$ 7,611,000	$ 7,741,667	$ 7,531,854
Contracts with health service providers	2,409,000	2,451,216	2,375,811
Contracts under the Health Care Protection Act	18,000	19,300	19,141
Drugs and gases	427,000	417,110	411,672
Medical and surgical supplies	390,000	414,053	403,626
Other contracted services	1,164,000	1,134,353	1,137,794
Other[a]	1,316,000	1,333,313	1,313,266
Amortization, disposals and write-downs (Note 18)	618,000	588,851	633,593
	$ 13,953,000	**$ 14,099,863**	**$ 13,826,757**
(a) Significant amounts included in Other are:			
Equipment expense		$ 208,119	$ 181,131
Other clinical supplies		149,183	141,884
Building rent		126,825	124,291
Utilities		107,608	118,766
Building and ground expenses		107,011	86,388
Housekeeping, laundry and linen, plant maintenance and biomedical engineering supplies		87,497	89,054
Food and dietary supplies		80,078	76,144
Minor equipment purchases		69,436	57,484
Office supplies		58,506	62,450
Fundraising and grants awarded		54,426	58,815
Telecommunications		42,070	44,945
Travel		39,462	43,131
Licenses, fees and memberships		24,803	25,434
Insurance		24,199	48,589
Education		13,628	16,026
Other		140,462	138,734
		$ 1,333,313	**$ 1,313,266**

SCHEDULE 2 - CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2016

	2016								2015	
	FTE[a]	Base Salary[b]	Other Cash Benefits[c]	Other Non-Cash Benefits[d]	Subtotal	Severance[e] Number of Individuals	Severance[e] Amount	Total	FTE[a][1]	Total[1]
Total Board (Sub-Schedule 2A)	4.42	$ -	$ 147	$ -	$ 147	-	$ -	$ 147	-	$ -
Total Former Official Administrator / Former Advisory Committees (Sub-Schedule 2B)	4.62	124	124	-	248	-	-	248	8.72	736
Total Executive (Sub-Schedule 2C)	14.38	5,126	113	768	6,007	2	559	6,566	14.57	6,668
Management Reporting to CEO Direct Reports	54.81	12,632	179	2,492	15,303	2	295	15,598	56.27	16,123
Other Management	3,093.23	366,475	2,630	85,721	454,826	4	283	455,109	3,108.27	459,227
Medical Doctors not included above[f]	156.89	49,034	639	3,355	53,028	1	98	53,126	165.56	54,254
Regulated nurses not included above:										
RNs, Reg. Psych. Nurses, Grad Nurses	18,773.62	1,731,921	263,215	391,104	2,386,240	1	6	2,386,246	18,609.99	2,338,268
LPNs	4,691.76	307,308	42,438	67,294	417,040	-	-	417,040	4,448.03	385,469
Other Health Technical & Professional	15,964.01	1,410,394	82,606	330,737	1,823,737	14	270	1,824,007	15,687.38	1,779,324
Unregulated Health Service Providers	8,542.13	427,916	58,710	98,710	585,336	-	-	585,336	8,344.09	552,739
Other Staff	25,707.59	1,549,951	103,293	344,541	1,997,785	18	459	1,998,244	25,511.64	1,939,046
Total	**77,007.46**	**$ 5,860,881**	**$ 554,094**	**$ 1,324,722**	**$ 7,739,697**	**42**	**$ 1,970**	**$ 7,741,667**	**75,954.52**	**$ 7,531,854**

(1) Certain 2015 amounts have been reclassified to conform to 2016 presentation.

The accompanying footnotes and sub-schedules are part of this schedule.

SUB-SCHEDULE 2A – BOARD REMUNERATION FOR THE YEAR ENDED MARCH 31, 2016

	Term	2016 Committees	2016 Remuneration	2015 Remuneration
Board Chair				
Linda Hughes	Since Nov 27, 2015	ARC, FC, GC, HRC, QSC	$ 26	$ -
Board Members				
Dr. Brenda Hemmelgarn (Vice Chair)	Since Nov 27, 2015	ARC, FC, GC, HRC, QSC	19	-
David Carpenter	Since Nov 27, 2015	ARC, FC, GC, HRC, QSC	14	-
Richard Dicerni[g]	Since Nov 27, 2015	ARC, FC, GC, HRC, QSC	-	-
Hugh Sommerville	Since Nov 27, 2015	ARC, FC, GC, HRC, QSC	13	-
Marliss Taylor	Since Nov 27, 2015	ARC, FC, GC, HRC, QSC	12	-
Glenda Yeates	Since Nov 27, 2015	ARC, FC, GC, HRC, QSC	13	-
Board Committee Participants[h]				
Barbara Burton	Nov 27, 2015 to Mar 31, 2016	HRC (Chair), QSC	12	-
Dr. Thomas Feasby	Since Nov 27, 2015	QSC	2	-
Martin Harvey	Nov 27, 2015 to Mar 31, 2016	HRC	1	-
Don Sieben	Nov 27, 2015 to Mar 31, 2016	ARC (Chair), FC (Chair), HRC, QSC	17	-
Doug Tupper	Nov 27, 2015 to Mar 31, 2016	ARC, FC, HRC, QSC (Chair)	17	-
Gord Winkel	Since Nov 27, 2015	QSC	1	-
Total Board			**$ 147**	**$ -**

Board members were remunerated with monthly honoraria. In addition, they receive remuneration for attendance at Board and committee meetings.

Board committees were established by the Board to assist in governing AHS and overseeing the management of AHS' business and affairs. Board committee participants are eligible to receive remuneration for meetings attended, and in addition Board committee chairs also receive a monthly honorarium.

Committee legend: ARC = Audit and Risk Committee, FC = Finance Committee, GC = Governance Committee, HRC = Human Resources Committee, QSC = Quality and Safety Committee

SUB-SCHEDULE 2B – FORMER OFFICIAL ADMINISTRATOR / FORMER ADVISORY COMMITTEES REMUNERATION FOR THE YEAR ENDED MARCH 31, 2016

	Term	2016 Committees	2016 Remuneration	2015 Remuneration
Former Official Administrator				
David Carpenter	Aug 25, 2015 to Nov 27, 2015	ARC, FC, HRAC, QSAC	$ 21	$ -
Dr. Carl Amrhein	Nov 17, 2014 to Aug 24, 2015	ARC, FC, HRAC, QSAC	129	186
Janet Davidson	Sep 10, 2014 to Nov 16, 2014	-	-	119
Dr. John Cowell	Sep 10, 2013 to Sep 9, 2014	-	-	295
Former Advisory Committee Participants[1]				
Barbara Burton	Dec 11, 2013 to Nov 26, 2015	HRAC (Chair), QSAC	25	6
Dr. Thomas Feasby	Jan 21, 2014 to Nov 26, 2015	QSAC	2	2
Martin Harvey	Dec 11, 2013 to Nov 26, 2015	HRAC	3	2
Gregory Henders	Dec 11, 2013 to Feb 13, 2015	-	-	2
Brian Olson	Sep 24, 2013 to Jan 31, 2015	-	-	33
Don Sieben	Sep 25, 2013 to Nov 26, 2015	ARC (Chair), FC (Chair), HRAC, QSAC	33	44
Doug Tupper	Nov 28, 2013 to Nov 26, 2015	ARC, FC, HRAC, QSAC (Chair)	33	44
Gord Winkel	Jan 21, 2014 to Nov 26, 2015	QSAC	2	3
Total Former Official Administrator / Former Advisory Committees			**$ 248**	**$ 736**

David Carpenter was appointed to the position of Official Administrator effective August 25, 2015 as per Ministerial Order 315/2015 with a term to end either on December 31, 2015 or in the event that a Board Chair is appointed, on the day that the Chair's appointment takes effect. The incumbent's term ended November 27, 2015 when the Board Chair's appointment took effect as per Ministerial Order 318/2015. The incumbent was remunerated with monthly honoraria of $5 and honoraria for attendance at AHS governance committee meetings up to a maximum limit of $3 per month.

Dr. Carl Amrhein was appointed to the position of Official Administrator as per Ministerial Order 314/2014 with a term that expired on June 30, 2015. During that term, the incumbent was on secondment from the University of Alberta. AHS reimbursed the University for the incumbent's base salary and benefits including annual performance adjustments. Remuneration was not to exceed $330 for the term. The incumbent was reappointed to the position of Official Administrator effective July 1, 2015 as per Ministerial Order 308/2015 with a term to end either on December 31, 2015 or in the event that a Board Chair is appointed, on the day that the Chair's appointment takes effect. The incumbent's term ended August 24, 2015 when Ministerial Order 308/2015 was repealed by Ministerial Order 315/2015. During the second term, the incumbent was remunerated with monthly honoraria of $5 and honoraria for attendance at AHS governance committee meetings up to a maximum limit of $3 per month. The incumbent received no remuneration from AHS for the month of August while holding both the positions of Official Administrator and Alberta Deputy Minister of Health.

Advisory committees were established by the Official Administrator to aid in governing AHS and overseeing the management of AHS' business and affairs. Advisory committee participants were eligible to receive honoraria for meetings attended. Advisory committee chairs were compensated an additional $30 per annum.

Committee legend: ARC = Audit and Risk Committee, FC = Finance Committee, HRAC = Human Resources Advisory Committee, QSAC = Quality and Safety Advisory Committee

SUB-SCHEDULE 2C - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2016

For the Current Fiscal Year	2016						
	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Board / Former Official Administrator Direct Reports							
Dr. Verna Yiu – Interim President and Chief Executive Officer [j,p,x]	0.23	$ 120	$ 22	$ 8	$ 150	$ -	$ 150
Vickie Kaminski – President and Chief Executive Officer [k]	0.85	462	31	32	525	-	525
Ronda White – Chief Audit Executive [y]	1.00	241	-	36	277	-	277
CEO Direct Reports							
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta [r]	1.00	372	-	50	422	-	422
Dr. Ted Braun – Acting VP and Medical Director, Central and Southern Alberta [l,r]	0.23	88	1	13	102	-	102
Dr. Francois Belanger – VP and Medical Director, Central and Southern Alberta [m,r]	0.77	348	-	66	414	-	414
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta [r]	1.00	372	-	32	404	-	404
Dr. David Mador – VP and Medical Director, Northern Alberta [aa]	1.00	452	-	70	522	-	522
Dave Bilan – Interim VP Collaborative Practice, Nursing and Health Professions [n,r]	0.34	57	-	9	66	-	66
Linda Dempster – VP Collaborative Practice, Nursing and Health Professions [o]	0.66	172	-	23	195	-	195
Dr. Francois Belanger – Interim VP, Quality and Chief Medical Officer [m,z]	0.23	104	-	20	124	-	124
Dr. Verna Yiu – VP, Quality and Chief Medical Officer [j,p,x]	0.77	402	36	26	464	-	464
Dr. Kathryn Todd – VP, Research, Innovation and Analytics [p,z]	1.00	264	15	29	308	-	308
Todd Gilchrist – VP, Human Resources [q,z]	0.91	406	-	123	529	-	529
Robert Armstrong – Acting VP, Human Resources [r]	0.09	22	3	6	31	-	31
Colleen Turner – Interim VP, Community Engagement and Communications [s,bb]	0.23	61	-	13	74	-	74
Carmel Turpin – VP, Community Engagement and Communications [t]	0.78	237	-	30	267	293	560
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer [z]	1.00	372	-	48	420	-	420
Noela Inions – Chief Ethics and Compliance Officer [z]	1.00	227	-	45	272	-	272
Vivian Simpkin – Interim General Counsel, Legal and Privacy [u,cc]	0.22	48	5	9	62	-	62
Salimah Walji-Shivji – General Counsel, Legal and Privacy [v,cc]	0.46	111	-	21	132	266	398
Sharon Lehr – Chief Program Officer, Operational Benchmarking and Efficiency [w]	0.61	188	-	59	247	-	247
Total Executive	**14.38**	**$ 5,126**	**$ 113**	**$ 768**	**$ 6,007**	**$ 559**	**$ 6,566**

SUB-SCHEDULE 2C - EXECUTIVE SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2016 (CONTINUED)

	2015						
For the Prior Fiscal Year	FTE [a]	Base Salary [b]	Other Cash Benefits [c]	Other Non-Cash Benefits [d]	Subtotal	Severance [e]	Total
Official Administrator Direct Reports							
Vickie Kaminski – President and Chief Executive Officer	0.85	$ 459	$ -	$ 88	$ 547	$ -	$ 547
Brenda Huband – Interim President and Chief Executive Officer, Zone and Health Operations	0.15	60	-	12	72	-	72
Rick Trimp – Interim President and Chief Executive Officer Population Heath and Province-Wide Services	0.15	60	-	8	68	-	68
Dr. Chris Eagle – Special Advisor	0.34	195	83	75	353	-	353
Ronda White – Chief Audit Executive	1.00	237	2	60	299	-	299
Catherine MacNeill – Acting Corporate Secretary	0.50	92	-	23	115	-	115
Kristin Long – Corporate Secretary	0.16	32	-	25	57	-	57
David Diamond – Chief External Relations Officer	0.61	196	12	35	243	-	243
CEO Direct Reports							
Brenda Huband – VP and Chief Health Operations Officer, Central and Southern Alberta	0.85	315	-	68	383	-	383
Dr. Francois Belanger – VP and Medical Director, Central and Southern Alberta	1.00	455	-	145	600	-	600
Deb Gordon – VP and Chief Health Operations Officer, Northern Alberta	1.00	371	-	83	454	-	454
Dr. David Mador – VP and Medical Director, Northern Alberta	1.00	455	-	92	547	-	547
Linda Dempster – VP Collaborative Practice, Nursing and Health Professions	0.02	5	-	2	7	-	7
Dr. Verna Yiu – VP, Quality and Chief Medical Officer	1.00	548	35	33	616	-	616
Rick Trimp – VP, Province-Wide Clinical Supports, Programs and Services	0.44	163	30	24	217	196	413
Mauro Chies – Acting VP, Province-Wide Clinical Supports, Programs and Services	0.15	35	8	8	51	-	51
Dr. Kathryn Todd – VP, Research, Innovation and Analytics	1.00	278	10	28	316	-	316
Robert Armstrong – Acting VP, Human Resources	0.75	184	26	43	253	-	253
Susan McGillivray – Acting VP, People	0.25	62	8	11	81	-	81
Carmel Turpin – VP, Community Engagement and Communications	0.41	119	-	31	150	-	150
Colleen Turner – Acting VP, Community Engagement and Communications	0.59	139	14	38	191	-	191
Deborah Rhodes – VP, Corporate Services and Chief Financial Officer	1.00	360	18	81	459	-	459
Noela Inions – Chief Ethics and Compliance Officer	1.00	226	-	58	284	-	284
Salimah Walji-Shivji – General Counsel, Legal and Privacy	0.35	84	-	25	109	-	109
Total Executive	**14.57**	**$ 5,130**	**$ 246**	**$ 1,096**	**$ 6,472**	**$ 196**	**$ 6,668**

SUB-SCHEDULE 2D - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN

Certain employees will receive retirement benefits that supplement the benefits limited under the registered plans for service. The Supplemental Pension Plan (SPP) is a defined contribution plan and the Supplemental Executive Retirement Plan (SERP) is a defined benefit plan. The SERP is disclosed in Note 2(h)(iii). The amounts in this table represent the total SPP and SERP benefits earned by the individual during the fiscal year. The current period benefit costs for SPP and the other costs for SERP included in other non-cash benefits disclosed in Sub-Schedule 2C are prorated for the period of time the individual was in their position directly reporting to the Board / former Official Administrator and directly reporting to the President and Chief Executive Officer. Only individuals holding a position directly reporting to either the Board / former Official Administrator or President and Chief Executive Officer during the current fiscal year are disclosed.

	2016			2015			
	SPP	SERP					
	Current period benefit costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2015	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2016
Dr. Verna Yiu - Interim President and Chief Executive Officer/ VP, Quality and Chief Medical Officer [6]	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Vickie Kaminski - President and Chief Executive Officer [5]	-	-	-	39	39	(39)	-
Ronda White - Chief Audit Executive	10	-	10	10	39	12	51
Brenda Huband - VP and Chief Health Operations Officer, Central and Southern Alberta							
SERP	-	(8)	(8)	9	412	10	422
SPP	25	-	25	26	67	28	95
Dr. Ted Braun - Acting VP and Medical Director, Central and Southern Alberta							
SERP	-	(4)	(4)	4	211	6	217
SPP	16	-	16	15	40	18	58
Dr. Francois Belanger - Interim VP, Quality and Chief Medical Officer/VP and Medical Director, Central and Southern Alberta	35	-	35	50	89	38	127
Deb Gordon - VP and Chief Health Operations Officer, Northern Alberta							
SERP	-	(11)	(11)	14	610	16	626
SPP	25	-	25	26	57	28	85
Dr. David Mador - VP and Medical Director, Northern Alberta	35	-	35	48	69	37	106
Dave Bilan - Interim VP Collaborative Practice, Nursing and Health Professions	-	-	-	-	-	-	-
Linda Dempster - VP Collaborative Practice, Nursing and Health Professions [5]	-	-	-	-	-	-	-
Dr. Kathryn Todd - VP, Research, Innovation and Analytics [6]	-	-	-	-	-	-	-
Todd Gilchrist - VP, Human Resources	31	-	31	-	-	31	31
Robert Armstrong - Acting VP, Human Resources	4	-	4	11	26	(26)	-
Colleen Turner - Interim VP, Community Engagement and Communications	10	-	10	10	37	11	48
Carmel Turpin - VP, Community Engagement and Communications [5]	-	-	-	7	7	(7)	-

SUB-SCHEDULE 2D - EXECUTIVE SUPPLEMENTAL PENSION PLAN AND SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (CONTINUED)

	2016			2015			
	SPP	SERP					
	Current period benefit costs[1]	Other Costs[2]	Total	Total	Account Balance[3] or Accrued Benefit Obligation March 31, 2015	Change During the Year[4]	Account Balance[3] or Accrued Benefit Obligation March 31, 2016
Deborah Rhodes - VP, Corporate Services and Chief Financial Officer	$ 25	$ -	$ 25	$ 25	$ 108	$ 30	$ 138
Noela Inions - Chief Ethics and Compliance Officer	8	-	8	8	54	10	64
Vivian Simpkin - Interim General Counsel, Legal and Privacy	5	-	5	9	20	(20)	-
Salimah Walji-Shivji - General Counsel, Legal and Privacy	5	-	5	6	26	(26)	-
Sharon Lehr - Chief Program Officer, Operational Benchmarking and Efficiency	15	-	15	-	-	15	15

(1) The SPP current period benefit costs are AHS contributions earned in the period.
(2) Other SERP costs include retirement benefits, interest expense on the obligations, and amortization of actuarial gains and losses, offset by the expected return on the plans' assets. AHS uses the straight line method to amortize actuarial gains and losses over the expected average remaining service life of the plan members. The SERP recovery is due to prior year unamortized net actuarial gains being recognized in 2015-16.
(3) The account balance represents the total cumulative earned contributions to the SPP as well as cumulative investment gains or losses on the contributions.
(4) Changes in the accrued benefit obligation include current period benefit cost, interest accruing on the obligations and the amortization of any actuarial gains or losses in the period. Changes in the account balance include the current benefit costs and investment gains or losses related to the account.
(5) The SPP had not fully vested at the time of the employee's departure, and as a result no current period benefit costs were incurred and the March 31, 2015 balance has been reversed accordingly.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2016

Definitions

a. For this schedule, full time equivalents (FTE) are determined by actual hours earned divided by 2,030.50 annual base hours. FTE for the Board / former Official Administrator and Committee members are prorated using the number of days in the fiscal year between either the date of appointment and the end of the year, the date of appointment and the termination date, or the beginning of the year and the termination date.

b. Base salary is regular salary and includes all payments earned related to actual hours earned other than those reported as other cash benefits. Base salary in the current fiscal year includes compensation for an additional day earned by employees due to the leap year.

Vacation accruals are included in base salary except for direct reports of the Board / former Official Administrator or President and Chief Executive Officer whose vacation accruals are included in other non-cash benefits.

c. Other cash benefits include, as applicable, honoraria, overtime, acting pay, travel and automobile allowances, lump sum payments and an allowance for professional development. Relocation expenses are excluded from compensation disclosure as they are considered to be recruiting costs to AHS and not part of compensation unless related to severance. Expense reimbursements are also excluded from compensation disclosure except where the expenses meet the definition of the other cash benefits listed above.

d. Other non-cash benefits include:
- Employer's current period benefit costs and other costs of supplemental pension plan and supplemental executive retirement plans as defined in Sub-Schedule 2D
- Employer's share of employee benefit contributions and payments made on behalf of employees including pension, health care, dental and vision coverage, out-of-country medical benefits, group life insurance, accidental disability and dismemberment insurance, and long and short-term disability plans, and
- Employer's share of the cost of additional benefits including sabbaticals or other special leave with pay.

Other non-cash benefits for executive were restated to include the AHS incurred expense in the fiscal year for the Health Spending and Personal Spending accounts for the incumbent where applicable. The prior year was restated to be comparable to current year presentation.

e. Severance includes direct or indirect payments to individuals upon termination which are not included in other cash benefits or other non-cash benefits.

f. Compensation provided by AHS for medical doctors included in salaries and benefits expense includes medical doctors paid through AHS payroll. The compensation provided by AHS for the remaining medical doctors is included in other contracted services.

Board and Advisory Committee Participants

g. This individual did not claim honoraria.

h. These individuals were participants of Board committees, but are not Board members or AHS employees.

Former Official Administrators and Former Advisory Committee Participants

i. These individuals were participants of Official Administrator governance advisory committees, but are not AHS employees.

Executive

j. The incumbent held the position of Vice President, Quality and Chief Medical Officer until January 11, 2016 at which time the incumbent was appointed to Interim President and Chief Executive Officer. The incumbent received acting pay while in the Interim President and Chief Executive Officer position. The incumbent was appointed President and Chief Executive Officer effective June 3, 2016.

k. The incumbent tendered their resignation letter on November 25, 2015 effective February 26, 2016. The incumbent held the position until February 5, 2016 at which time the incumbent left AHS. At the time of their departure the incumbent received a lump sum payment of $31 in lieu of the completion of the notice period included in Other cash benefits. In addition, the incumbent received a vacation payout of $71 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

l. The incumbent held the position of Associate Zone Medical Director, Calgary Zone until January 11, 2016 at which time the incumbent was appointed to Acting Vice President and Medical Director, Central and Southern Alberta and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in base salary while in the Acting Vice President and Medical Director, Central and Southern Alberta position.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2016 (CONTINUED)

m. The incumbent held the position of Vice President and Medical Director, Central and Southern Alberta until January 11, 2016 at which time the incumbent was appointed to Interim Vice President, Quality and Chief Medical Officer.

n. The incumbent held the position of Executive Director, Health Professions – Strategy and Practice until November 27, 2015 at which time the incumbent was appointed to Interim Vice President, Collaborative Practice, Nursing and Health Professions and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in base salary while in the Interim Vice President, Collaborative Practice, Nursing and Health Professions position.

o. The incumbent held the position until November 27, 2015 at which time the incumbent left AHS. At this time the incumbent received a vacation payout of $31 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

p. The incumbent is on secondment from the University of Alberta. The incumbent's total remuneration is comprised of salary amounts from both AHS and the University of Alberta. AHS reimburses the University for the incumbent's base salary and benefits including annual performance adjustments. In lieu of enrollment into the AHS SPP, the incumbent will receive an annual lump sum supplemental payment equivalent to the amount the incumbent would have received as a member of the SPP and payable from AHS. The lump sum has been included in Other Cash Benefits.

q. The incumbent was appointed to the position effective May 4, 2015.

r. The incumbent held the position of Acting Vice President, Human Resources and received acting pay until May 3, 2015 at which time the incumbent resumed the role of Senior Program Officer, HR Shared Services, Workforce Strategies and Total Rewards and was no longer a direct report to the President and Chief Executive Officer.

s. The incumbent held the position of Senior Program Officer, Communications until January 11, 2016 at which time the incumbent was appointed to Interim Vice President Community Engagement and Communications and became a direct report to the President and Chief Executive Officer. The incumbent received an increase in base salary while in the Interim Vice President, Community Engagement and Communications position.

t. The incumbent held the position until January 11, 2016 at which time the incumbent left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 40 weeks base salary at the rate in effect at the date of departure, 15% of the severance in lieu of benefits, and 10% of the severance for purposes of relocation expenses. AHS will also make payments for the incumbent to attend an outplacement program for a maximum of six months. In addition, the incumbent received a vacation payout of $24 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

u. The incumbent held the position of Associate General Counsel, Corporate & Commercial Law until September 16, 2015 at which time the incumbent was appointed to Interim General Counsel, Legal and Privacy and became a direct report to the President and Chief Executive Officer. The incumbent received acting pay while in the Interim General Counsel, Legal and Privacy position. The incumbent held the Interim General Counsel, Legal & Privacy position until December 4, 2015 at which time the incumbent left AHS. At this time the incumbent received a vacation payout of $29 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned. As a result of restructuring, the position of General Counsel, Legal & Privacy ceased to be a direct report to the President and Chief Executive Officer effective December 7, 2015.

v. The incumbent held the position until September 16, 2015 at which time the incumbent left AHS. The incumbent received salary and other accrued entitlements to the date of departure. The reported severance included 50 weeks base salary at the rate in effect at the date of departure and 15% of the severance in lieu of benefits. AHS will also make payments for the incumbent to attend an outplacement program for a maximum of six months. In addition, the incumbent received a vacation payout of $56 for unused accrued vacation at the time of departure; accrued vacation has been recorded in their compensation as a non-cash benefit in the period it was earned.

w. The incumbent was appointed to the position effective June 1, 2015. As a result of restructuring, the incumbent ceased to be a direct report to the President and Chief Executive Officer effective January 11, 2016.

Termination Obligations

x. There is no severance associated with the secondment agreement. Upon termination of the secondment agreement, the incumbent would return to the incumbent's regular position at the University of Alberta.

y. In the case of termination without just cause by AHS, the incumbent shall receive severance pay equal to 12 months base salary. The severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

z. The incumbent's termination benefits have not been predetermined.

FOOTNOTES TO THE CONSOLIDATED SCHEDULE OF SALARIES AND BENEFITS FOR THE YEAR ENDED MARCH 31, 2016 (CONTINUED)

aa. In the case of termination without just cause by AHS, the incumbent shall receive severance pay to a maximum of 12 months base salary plus market supplement. Such severance will be paid in 12 equal monthly instalments. The severance payment will be reduced by any employment earnings received from a new employer within the 12 month period.

bb. In the case of termination without just cause by AHS, the incumbent shall receive severance pay to a maximum of 12 months base salary. The incumbent will also be paid 15% of the severance in lieu of other benefits.

cc. SPP

Based on the provision of the applicable SPP, the following outlines the benefits received by individuals who terminated employment with AHS within the 2015-16 fiscal period. As a result of retirement or termination, the incumbents are entitled to the benefits accrued to them up to the date of retirement or termination. For participants of SPP, the benefit includes the account balances as at March 31, 2015 and the current period benefit costs and investment gains or losses related to the account that were incurred during the current year. The AHS obligations are paid through either a lump sum payment or regular instalments:

Position[1]	Supplemental Plan Commencement Date	Benefit (not in thousands)	Frequency	Payment Terms
Interim General Counsel, Legal and Privacy (SPP)	December 20, 2010	$25,835	Once	January 2016
General Counsel, Legal and Privacy (SPP)	December 20, 2010	$30,818	Once	October 2015

(1) Pertains only to those individuals for which the applicable SPP were fully vested at the time their employment with AHS ended.

SCHEDULE 3 – ADJUSTMENTS DUE TO CHANGES IN ACCOUNTING POLICY AND OTHER RECLASSIFICATIONS FOR THE YEAR ENDED MARCH 31

(a) Reconciliation of the Approved Budget for the Consolidated Statement of Operations

	2016 Approved Budget	Changes in Accounting Policy (Note 2(l))	Other Reclassifications[a]	2016 Reported Budget
Revenue:				
Alberta Health transfers				
Base operating	$ 11,330,000	$ -	$ -	$ 11,330,000
Other operating	1,110,000	-	-	1,110,000
Capital	84,000	-	-	84,000
Other government transfers	416,000	-	-	416,000
Fees and charges	507,000	-	-	507,000
Ancillary operations	132,000	-	-	132,000
Donations, fundraising, and non-government contributions	166,000	-	-	166,000
Investment and other income	208,000	-	-	208,000
TOTAL REVENUE	**13,953,000**	**-**	**-**	**13,953,000**
Expenses:				
Inpatient acute nursing services	3,210,000	-	(53,000)	3,157,000
Emergency and other outpatient services	1,620,000	-	(1,000)	1,619,000
Facility-based continuing care services	984,000	-	63,000	1,047,000
Ambulance services	468,000	-	-	468,000
Community-based care	1,227,000	-	(5,000)	1,222,000
Home care	536,000	-	6,000	542,000
Diagnostic and therapeutic services	2,329,000	-	(81,000)	2,248,000
Promotion, prevention, and protection services	376,000	-	3,000	379,000
Research and education	238,000	-	2,000	240,000
Administration	450,000	-	4,000	454,000
Information technology	565,000	-	1,000	566,000
Support services	1,950,000	-	61,000	2,011,000
TOTAL EXPENSES (Schedule 1)	**13,953,000**	**-**	**-**	**13,953,000**
ANNUAL OPERATING SURPLUS (DEFICIT)	-	-	-	-
Endowment contributions and reinvested income	-	-	-	-
ANNUAL SURPLUS (DEFICIT)	$ -	$ -	$ -	$ -

(a) In 2015-16, AHS reclassified prior year comparatives to conform with current year presentation due to:
- i) a change in methodology related to expense allocations for contracts with health service providers, and
- ii) better alignment of transactions with Alberta Health and the CIHI standards.

SCHEDULE 3 – ADJUSTMENTS DUE TO CHANGES IN ACCOUNTING POLICY AND OTHER RECLASSIFICATIONS FOR THE YEAR ENDED MARCH 31

(b) Reconciliation of the Prior Year Comparative for the Consolidated Statement of Operations

	2015 as Previously Presented	Changes in Accounting Policy (Note 2(l))	Other Reclassifications[a]	2015 Revised
Revenue:				
Alberta Health transfers				
Base operating	$ 10,851,204	$ -	$ -	$ 10,851,204
Other operating	1,378,438	-	-	1,378,438
Capital	92,907	-	-	92,907
Other government transfers (Note 4)	420,599	-	-	420,599
Fees and charges	445,912	-	26,477	472,389
Ancillary operations	133,118	-	-	133,118
Donations, fundraising, and non-government contributions (Note 5)	167,290	-	-	167,290
Investment and other income (Note 6)	308,308	-	-	308,308
TOTAL REVENUE	**13,797,776**	**-**	**26,477**	**13,824,253**
Expenses:				
Inpatient acute nursing services	3,247,819	-	(34,011)	3,213,808
Emergency and other outpatient services	1,581,887	-	4,178	1,586,065
Facility-based continuing care services	940,411	-	65,385	1,005,796
Ambulance services	468,031	-	7,399	475,430
Community-based care	1,139,337	-	(1,311)	1,138,026
Home care	530,501	-	5,116	535,617
Diagnostic and therapeutic services	2,314,445	-	(79,583)	2,234,862
Promotion, prevention, and protection services	358,933	-	1,978	360,911
Research and education	232,162	-	3,249	235,411
Administration (Note 7)	448,491	-	(461)	448,030
Information technology	567,792	-	1,069	568,861
Support services (Note 8)	1,970,471	-	53,469	2,023,940
TOTAL EXPENSES (Schedule 1)	**13,800,280**	**-**	**26,477**	**13,826,757**
ANNUAL OPERATING SURPLUS (DEFICIT)	**(2,504)**	**-**	**-**	**(2,504)**
Endowment contributions and reinvested income	-	3,585	-	3,585
ANNUAL SURPLUS (DEFICIT)	**$ (2,504)**	**$ 3,585**	**$ -**	**$ 1,081**
Accumulated surplus, beginning of year	1,233,805	-	68,796	1,302,601
Accumulated surplus, end of year (Note 19)	**$ 1,231,301**	**$ 3,585**	**$ 68,796**	**$ 1,303,682**

(a) In 2015-16, AHS reclassified prior year comparatives to conform with current year presentation due to:

i) a change in methodology related to expense allocations for contracts with health service providers,

ii) better alignment of transactions with Alberta Health and the CIHI standards, and

iii) the reclassification of bad debts expense from net of revenues to expenses.

SCHEDULE 3 – ADJUSTMENTS DUE TO CHANGES IN ACCOUNTING POLICY AND OTHER RECLASSIFICATIONS FOR THE YEAR ENDED MARCH 31

(c) Reconciliation of the Prior Year Comparative for the Consolidated Statement of Financial Position

	2015 as Previously Presented	Changes in Accounting Policy (Note 2(l))	Other Reclassifications[a]	2015 Revised
Financial Assets:				
Cash	$ 549,779	$ -	$ (217,932)	$ 331,847
Portfolio investments (Note 10)	1,955,561	-	217,932	2,173,493
Accounts receivable (Note 11)	313,972	-	-	313,972
Other assets	12,179	-	-	12,179
Tangible capital assets	7,511,137	(7,511,137)	-	-
Inventories for consumption	96,583	(96,583)	-	-
Prepaid expenses	126,610	(126,610)	-	-
	10,565,821	(7,734,330)	-	2,831,491
Liabilities:				
Accounts payable and accrued liabilities (Note 12)	1,256,333	-	17,566	1,273,899
Employee future benefits (Note 13)	594,603	-	-	594,603
Deferred revenue	7,033,031	(7,033,031)	-	-
Unexpended deferred operating revenue (Note 14)	-	491,254	-	491,254
Unexpended deferred capital revenue (Note 15)	-	178,078	-	178,078
Debt (Note 17)	339,397	-	(17,566)	321,831
	9,223,364	(6,363,699)	-	2,859,665
NET DEBT	**-**	**-**	**-**	**(28,174)**
Non-Financial Assets:				
Tangible capital assets (Note 18)	-	7,511,137	-	7,511,137
Inventories for consumption	-	96,583	-	96,583
Prepaid expenses	-	126,610	-	126,610
	-	7,734,330	-	7,734,330
NET ASSETS BEFORE EXPENDED DEFERRED CAPITAL REVENUE	-	7,706,156	-	7,706,156
Expended deferred capital revenue (Note 16)	-	6,363,699	-	6,363,699
NET ASSETS	**-**	**1,342,457**	**-**	**1,342,457**
Net assets is comprised of:				
Accumulated surplus (Note 19)	1,231,301	-	72,381	1,303,682
Accumulated remeasurement gains and losses	38,775	-	-	38,775
Endowments	72,381	-	(72,381)	-
	$ 1,342,457	**$ -**	**$ -**	**$ 1,342,457**

(a) In 2015-16, AHS reclassified prior year comparatives to conform with current year presentation due to:
   i) cash equivalents deemed to be held for investment purposes reclassified to portfolio investments, and
   ii) capital lease obligations reclassified from debt to accounts payable and accrued liabilities due to better alignment of presentation of transactions with Alberta Health.

SCHEDULE 3 – ADJUSTMENTS DUE TO CHANGES IN ACCOUNTING POLICY AND OTHER RECLASSIFICATIONS FOR THE YEAR ENDED MARCH 31

(d) Reconciliation of the Prior Year Comparative for the Consolidated Statement of Cash Flows

	2015 as Previously Presented	Changes in Accounting Policy (Note 2(l))	Other Reclassifications[a]	2015 Revised
Operating transactions:				
Annual surplus (deficit)	$ (2,504)	$ 3,585	$ -	$ 1,081
Non-cash items:				
Amortization, disposals, and write-downs	633,593	-	-	633,593
Recognition of expended deferred capital revenue	(427,506)	-	-	(427,506)
Revenue recognized for acquisition of land	-	-	-	-
Decrease (increase) in:				
Accounts receivable related to operating transactions	72,533	-	-	72,533
Inventories for consumption	1,669	-	-	1,669
Other assets	(575)	-	-	(575)
Prepaid expenses	(20,211)	-	-	(20,211)
Increase (decrease) in:				
Accounts payable and accrued liabilities related to operating transactions	85,372	-	-	85,372
Employee future benefits	40,071	-	-	40,071
Deferred revenue related to operating transactions	(70,906)	(3,585)	-	(74,491)
Cash provided by (applied to) operating transactions	311,536	-	-	311,536
Capital transactions:				
Acquisition of tangible capital assets	(229,734)	-	-	(229,734)
Increase (decrease) in accounts payable and accrued liabilities related to capital transactions	(30,566)	-	(1,231)	(31,797)
Cash provided by (applied) to capital transactions	(260,300)	-	(1,231)	(261,531)
Investing transactions:				
Purchase of portfolio investments	(3,134,674)	-	(1,069,279)	(4,203,953)
Proceeds on disposals of portfolio investments	2,955,055	-	1,336,843	4,291,898
Cash provided by (applied to) investing transactions	(179,619)	-	267,564	87,945
Financing transactions:				
Restricted capital revenue received	96,977	-	-	96,977
Restricted capital revenue returned	(14,119)	-	-	(14,119)
Proceeds from debt	5,772	-	(772)	5,000
Principal payments on debt	(16,538)	-	2,003	(14,535)
Cash provided by (applied to) financing transactions	72,092	-	1,231	73,323
Net increase (decrease) in cash	**(56,291)**	**-**	**267,564**	**211,273**
Cash, beginning of year	606,070	-	(485,496)	120,574
Cash, end of year	**$ 549,779**	**$ -**	**$ (217,932)**	**$ 331,847**

(a) In 2015-16, AHS reclassified prior year comparatives to conform with current year presentation due to:
- i) cash equivalents deemed to be held for investment purposes reclassified to portfolio investments, and
- ii) capital lease obligations reclassified from debt to accounts payable and accrued liabilities due to better alignment of presentation of transactions with Alberta Health.

SCHEDULE 3 – ADJUSTMENTS DUE TO CHANGES IN ACCOUNTING POLICY AND OTHER RECLASSIFICATIONS FOR THE YEAR ENDED MARCH 31

(e) Reconciliation of the Prior Year Comparative for the Consolidated Schedule of Expenses by Object

	2015 as Previously Presented	Changes in Accounting Policy (Note 2(l))	Other Reclassifications[a]	2015 Revised
Salaries and benefits (Schedule 2)	$ 7,531,854	$ -	$ -	$ 7,531,854
Contracts with health service providers	2,375,811	-	-	2,375,811
Contracts under the Health Care Protection Act	19,141	-	-	19,141
Drugs and gases	411,672	-	-	411,672
Medical and surgical supplies	403,626	-	-	403,626
Other contracted services	1,137,794	-	-	1,137,794
Other	1,286,789	-	26,477	1,313,266
Amortization, disposals and write-downs (Note 18)	633,593	-	-	633,593
	$ 13,800,280	**$ -**	**$ 26,477**	**$ 13,826,757**

(a) In 2015-16, AHS reclassified prior year comparatives to conform with current year presentation due to the reclassification of bad debts expense from net of revenues to expenses.

Compensation Analysis and Discussion

(Non-Union/Exempt Employees)

A total compensation strategy is the blueprint for an organization's total compensation program. It includes the mix of direct and indirect compensation to be provided to employees and the means through which it will be provided in order to support an organization's goals. It is important that total compensation in a publicly-funded organization such as AHS has a governance-approved strategy or "blueprint" that is properly aligned with its direction, goals and values.

Total Compensation Philosophy

AHS reinforces outstanding patient care for all Albertans by attracting, retaining and engaging talented and committed employees. We do this with competitive and fair total compensation that motivates and rewards performance while demonstrating sound fiscal management and sustainability. Principles set out in the total compensation policy guided by AHS' total compensation philosophy reflect:

- Competitive market positioning.
- Internal equity.
- Performance orientation.
- Affordability.
- Individual flexibility.
- Shared employee/employer responsibility.

Total Compensation Strategy

AHS ensures the process used to set total compensation, establish and maintain good governance, and incorporate best practices is transparent. The job rates for Executive and Senior Leadership salary ranges are representative of the median of the national health care and Alberta public sector market. To ensure total compensation remains market competitive, AHS reviews its market positioning on a regular basis and, in any event, no less than once every second year. Salary ranges are published on the AHS website.

AHS' Total Compensation programs and practices encourage behaviours that will promote a patient-focused, quality health system that is accessible and sustainable for all Albertans.

Total Compensation Plan Structure

AHS is committed to providing a comprehensive total compensation package including salary, benefits, pension and other programs and services that support attracting, retaining and engaging talented and committed employees. AHS' total compensation is comprised of direct and indirect compensation. Elements within direct and indirect compensation fit the overall total compensation strategy by driving accountability and performance, demonstrating sound fiscal management, and promoting a sense of integrity and equity.

Direct Compensation includes pay received as wages and salaries. It integrates with the AHS Performance Management Program. AHS has no incentive, variable pay or pay at risk of any kind.

Base salary ranges are intended to be competitive compared to the median (50th percentile) of the national health care market and the Alberta public sector market. An employee's individual base salary is set based on individual performance and salary range adjustments within AHS market comparators.

Indirect Compensation includes benefits and pension (including supplemental pension plan), terms and conditions, and employee appreciation. AHS' benefits and pension plans support the health and well-being of our employees and financial security upon retirement.

AHS provides a competitive benefits program that includes pension, health and dental-care benefits, life insurance, illness and long-term disability coverage and professional memberships.

All AHS employees participate in the Local Authorities Pension Plan (LAPP). This is a defined benefit pension plan. It provides for a pension of 1.4 per cent for each year of pensionable service based on the average salary of the highest five consecutive years up to the Year's Maximum Pensionable Earnings under the Canada Pension Plan and 2.0 per cent on the excess. Benefits under this plan are capped at the maximum pension benefit limit allowed under the federal *Income Tax Act*, a salary of $160,970 in 2016.

As pensionable earnings are limited under LAPP, AHS provides a Supplemental Pension Plan (SPP). Unlike the Local Authorities Pension, the SPP is a Defined Contribution plan that provides annual notional contributions that are allocated to and invested as directed by each member. The SPP allows AHS to maintain a competitive position, but at less cost and risk to the organization.

AHS does not provide car allowances or perquisite allowances to its executives or employees.

Total Compensation Governance

The Human Resources Committee of the Board monitors, oversees and advises the Board on total compensation matters related to AHS including:

- Determining the overall strategic approach to compensation.
- Reviewing substantive changes to total compensation programs to ensure they support the organization's mission, strategic directions and values.
- Reviewing the compensation of the President & Chief Executive Officer (CEO) and Vice Presidents.
- Reviewing the compensation philosophy recommended by the President & CEO for non-executive staff of AHS.

Total Compensation Reporting

The Schedule 2 – Consolidated Schedule of Salaries and Benefits in the annual audited consolidated financial statements for the year ended March 31, 2016, provides complete disclosure of salary, benefits, and all other compensation earned for years ended March 31, 2016 and March 31, 2015 by the direct reports to the Board and direct reports to the President & CEO. The Board's compensation is disclosed in Schedule 2 – Consolidated Schedule of Salaries and Benefits in the annual audited consolidated financial statements for the year ended March 31, 2016.

The Schedule 2 Information on total compensation philosophy and practices can be found on the AHS website at www.ahs.ca/204.asp.

Total Compensation 2015-16 Information Updates

The *Public Service Compensation Transparency Act* increases transparency by requiring compensation disclosure from Alberta agencies, boards and commissions including AHS. AHS is required to disclose the names and compensation of employees whose earnings are over $125,000 per year. The first AHS disclosure under the Act is required by June 24, 2016, and will be posted on AHS' external website.

The Alberta government has frozen salaries for all non-union/exempt employees at provincial agencies, boards and commissions as part of the province's ongoing restraint measures to reduce government operating costs. AHS is among the organizations affected by the freeze. The freeze will be in effect for two years, beginning April 1, 2016.

Appendix

- Zone Quick Facts
- Partner Foundations and Health Trusts
- Public Interest Disclosure (Whistleblower Protection) Act
- Surgical Contracts
- AHS-Funded Facilities
- Zone Overview of Beds and Spaces

Zone Quick Facts

South Zone	2012-13	2013-14	2014-15	2015-16	% Change from 2014-15 to 2015-16	% of Province
Primary Care / Population Health						
Number of Unique Home Care Clients	11,144	11,577	12,044	12,060	0.1%	10.4%
Number of People Placed in Continuing Care	930	868	866	887	2.4%	11.3%
Health Link Calls	28,077	32,186	32,108	34,773	8.3%	4.6%
Seasonal Influenza Immunizations	75,488	89,634	96,663	88,172	-8.8%	7.7%
Food Safety Inspections	9,014	8,402	8,609	7,866	-8.6%	8.5%
Acute Care						
Emergency Department Visits (all sites)	202,797	196,577	194,353	194,257	0.0%	9.1%
Hospital Discharges	31,640	31,093	31,125	30,485	-2.1%	7.5%
Births	4,124	3,973	4,156	4,217	1.5%	7.6%
Total Hospital Days	197,445	199,672	212,020	219,218	3.4%	7.8%
Average Length of Stay (in days)	6.2	6.4	6.8	7.2	5.6%	n/a
Diagnostic / Specific Procedures						
Total Hip Replacements (scheduled and emergency)	513	526	571	578	1.2%	10.4%
Total Knee Replacements (scheduled and emergency)	832	804	822	838	1.9%	12.6%
Cataract Surgery	2,514	2,653	2,878	2,847	-1.1%	7.8%
Main Operating Room Activity	22,396	23,049	23,501	23,209	-1.2%	8.3%
MRI Exams	13,875	13,380	14,227	14,288	0.4%	7.3%
CT Exams	22,724	24,906	26,185	26,964	3.0%	6.9%
X-rays	151,898	156,503	163,095	166,251	1.9%	8.9%
Lab Tests	4,598,753	4,843,124	5,085,305	5,263,114	3.5%	7.0%
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	32,645	31,529	30,277	32,144	6.2%	5.2%
Unique Cancer Patients	4,775	4,522	4,349	4,273	-1.7%	7.8%
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	2,038	2,019	2,026	2,058	1.6%	9.0%
Staffing						
Head Count	6,874	6,947	7,238	7,280	0.6%	7.3%
Volunteers	2,433	2,130	1,933	1,746	-9.7%	11.0%
AHS Physicians*	n/a	n/a	704	569	-19.2%	7.2%

* Decrease in physician numbers is attributed to South Zone joining the provincial appointment and privileging database. Reconciliation of database has reduced duplication of records.

Calgary Zone	2012-13	2013-14	2014-15	2015-16	% Change from 2014-15 to 2015-16	% of Province
Primary Care / Population Health						
Number of Unique Home Care Clients	31,832	32,648	33,548	34,690	3.4%	29.8%
Number of People Placed in Continuing Care	2,301	2,164	2,548	2,722	6.8%	34.5%
Health Link Calls	319,859	325,215	325,566	318,422	-2.2%	42.2%
Seasonal Influenza Immunizations	372,337	461,442	511,151	467,942	-8.5%	40.8%
Food Safety Inspections	30,372	31,805	31,121	30,496	-2.0%	32.8%
Acute Care						
Emergency Department Visits (all sites)	450,901	485,803	493,861	487,879	-1.2%	22.9%
Urgent Care Visits	185,706	181,377	183,230	179,825	-1.9%	94.8%
Hospital Discharges	130,842	136,598	140,563	143,057	1.8%	35.4%
Births	18,452	18,865	19,554	19,721	0.9%	35.7%
Total Hospital Days	938,601	959,949	1,025,776	1,030,081	0.4%	36.6%
Average Length of Stay (in days)	7.2	7.0	7.3	7.2	-1.3%	n/a
Diagnostic / Specific Procedures						
Total Hip Replacements (scheduled and emergency)	1,815	1,897	1,960	2,099	7.1%	37.7%
Total Knee Replacements (scheduled and emergency)	1,934	2,185	2,388	2,511	5.2%	37.8%
Cataract Surgery	13,131	13,799	13,378	13,469	0.7%	36.7%
Main Operating Room Activity	90,211	94,403	97,177	99,633	2.5%	35.4%
MRI Exams	64,061	75,273	78,175	76,850	-1.7%	39.3%
CT Exams	125,906	134,515	143,496	142,863	-0.4%	36.5%
X-rays	520,147	539,337	541,087	546,546	1.0%	29.2%
Lab Tests	25,659,121	26,521,983	28,407,412	28,800,430	1.4%	38.1%
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	179,172	176,552	180,811	200,599	10.9%	32.6%
Unique Cancer Patients	20,646	20,926	21,717	22,934	5.6%	41.7%
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	7,052	7,798	8,150	9,067	11.3%	39.8%
Staffing						
Head Count	35,839	35,909	37,000	37,023	0.1%	36.9%
Volunteers	4,686	4,165	4,623	5,100	10.3%	32.0%
AHS Physicians	n/a	n/a	3,076	3,326	8.1%	41.9%

Central Zone	2012-13	2013-14	2014-15	2015-16	% Change from 2014-15 to 2015-16	% of Province
Primary Care / Population Health						
Number of Unique Home Care Clients	16,962	17,483	18,245	18,370	0.7%	15.8%
Number of People Placed in Continuing Care	1,281	1,189	1,259	1,060	-15.8%	13.5%
Health Link Calls	58,686	57,847	62,035	68,388	10.2%	9.1%
Seasonal Influenza Immunizations	86,453	109,014	115,539	105,872	-8.4%	9.2%
Food Safety Inspections	12,443	10,626	11,234	11,390	1.4%	12.3%
Acute Care						
Emergency Department Visits (all sites)	379,557	372,122	380,371	360,965	-5.1%	16.9%
Hospital Discharges	45,619	44,589	45,691	45,578	-0.2%	11.3%
Births	4,869	4,812	4,926	5,037	2.3%	9.1%
Total Hospital Days	319,977	322,478	330,752	323,984	-2.0%	11.5%
Average Length of Stay (in days)	7.0	7.2	7.2	7.1	-1.8%	n/a
Diagnostic / Specific Procedures						
Total Hip Replacements (scheduled and emergency)	566	574	569	586	3.0%	10.5%
Total Knee Replacements (scheduled and emergency)	649	669	654	616	-5.8%	9.3%
Cataract Surgery	3,489	3,495	3,722	3,782	1.6%	10.3%
Main Operating Room Activity	27,967	27,847	29,330	29,999	2.3%	10.7%
MRI Exams	12,204	13,137	12,610	12,406	-1.6%	6.3%
CT Exams	31,575	33,708	36,143	37,485	3.7%	9.6%
X-rays	261,541	259,979	256,595	255,147	-0.6%	13.6%
Lab Tests	6,012,138	6,088,885	6,187,163	6,374,514	3.0%	8.4%
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	15,508	18,686	27,298	32,098	17.6%	5.2%
Unique Cancer Patients	2,001	2,172	2,461	2,762	12.2%	5.0%
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	2,342	2,169	2,281	2,514	10.2%	11.0%
Staffing						
Head Count	12,210	12,361	12,631	12,772	1.1%	12.7%
Volunteers	3,296	3,297	3,292	3,409	3.6%	21.4%
AHS Physicians	n/a	n/a	707	710	0.4%	8.9%

Edmonton Zone	2012-13	2013-14	2014-15	2015-16	% Change from 2014-15 to 2015-16	% of Province
Primary Care / Population Health						
Number of Unique Home Care Clients	37,604	38,011	38,183	37,554	-1.6%	32.2%
Number of People Placed in Continuing Care	2,620	2,742	2,443	2,506	2.6%	31.8%
Health Link Calls	283,410	296,362	325,440	269,205	-17.3%	35.6%
Seasonal Influenza Immunizations	298,712	387,959	417,388	384,723	-7.8%	33.6%
Food Safety Inspections	28,234	29,678	26,170	27,788	6.2%	29.9%
Acute Care						
Emergency Department Visits (all sites)	492,014	502,838	535,147	541,453	1.2%	25.4%
Urgent Care Visits	18,896	23,977	12,082	9,943	-17.7%	5.2%
Hospital Discharges	132,337	135,970	139,052	141,282	1.6%	34.9%
Births	17,848	18,374	19,258	19,748	2.5%	35.7%
Total Hospital Days	933,710	940,976	984,395	975,065	-0.9%	34.7%
Average Length of Stay (in days)	7.1	6.9	7.1	6.9	-2.5%	n/a
Diagnostic / Specific Procedures						
Total Hip Replacements (scheduled and emergency)	2,040	1,936	1,957	1,985	1.4%	35.7%
Total Knee Replacements (scheduled and emergency)	2,305	2,156	2,068	2,167	4.8%	32.6%
Cataract Surgery	14,480	14,525	14,411	14,460	0.3%	39.4%
Main Operating Room Activity	102,857	104,219	102,467	102,438	0.0%	36.4%
MRI Exams	73,570	75,665	81,945	78,254	-4.5%	40.0%
CT Exams	133,007	139,743	147,226	149,237	1.4%	38.1%
X-rays	585,759	597,028	609,179	613,135	0.6%	32.7%
Lab Tests	25,730,945	26,734,776	27,107,881	27,781,396	2.5%	36.8%
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	320,344	319,104	325,538	337,234	3.6%	54.7%
Unique Cancer Patients	22,769	23,507	23,868	25,074	5.1%	45.6%
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	5,861	6,061	5,978	6,188	3.5%	27.1%
Staffing						
Head Count	31,380	31,497	32,657	32,921	0.8%	32.8%
Volunteers	3,052	2,522	2,680	2,903	8.3%	18.2%
AHS Physicians	n/a	n/a	2,659	2,714	2.1%	34.2%

North Zone	2012-13	2013-14	2014-15	2015-16	% Change from 2014-15 to 2015-16	% of Province
Primary Care / Population Health						
Number of Unique Home Care Clients	11,642	12,343	12,970	13,788	6.3%	11.8%
Number of People Placed in Continuing Care	629	731	694	704	1.4%	8.9%
Health Link Calls	65,948	66,743	68,322	64,546	-5.5%	8.5%
Seasonal Influenza Immunizations	86,358	109,501	114,209	99,860	-12.6%	8.7%
Food Safety Inspections	14,793	14,878	15,589	15,317	-1.7%	16.5%
Acute Care						
Emergency Department Visits (all sites)	591,677	585,294	577,643	550,414	-4.7%	25.8%
Hospital Discharges	45,098	45,515	44,900	44,111	-1.8%	10.9%
Births	6,247	6,299	6,309	6,558	3.9%	11.9%
Total Hospital Days	250,804	247,759	256,047	263,379	2.9%	9.4%
Average Length of Stay (in days)	5.6	5.4	5.7	6.0	4.7%	n/a
Diagnostic / Specific Procedures						
Total Hip Replacements (scheduled and emergency)	282	310	340	315	-7.4%	5.7%
Total Knee Replacements (scheduled and emergency)	396	410	445	514	15.5%	7.7%
Cataract Surgery	2,102	2,313	2,194	2,142	-2.4%	5.8%
Main Operating Room Activity	23,038	23,190	23,450	26,033	11.0%	9.3%
MRI Exams	12,995	12,569	12,971	13,621	5.0%	7.0%
CT Exams	31,455	32,309	34,066	35,051	2.9%	9.0%
X-rays	296,496	295,275	298,088	293,800	-1.4%	15.7%
Lab Tests	4,672,572	4,774,459	4,883,055	5,038,109	3.2%	6.7%
Cancer Care						
Cancer Patient Visits (patients may have multiple visits)	13,956	14,469	14,081	14,162	0.6%	2.3%
Unique Cancer Patients	2,121	2,272	2,199	2,318	5.4%	4.2%
Addiction & Mental Health						
Mental Health Hospital Discharges (acute care sites)	2,662	2,961	2,994	2,983	-0.4%	13.1%
Staffing						
Head Count	9,804	9,987	10,411	10,403	-0.1%	10.4%
Volunteers	4,482	3,356	3,083	2,774	-10.0%	17.4%
AHS Physicians	n/a	n/a	579	607	4.8%	7.6%

Partner Foundations & Health Trusts

Foundations and health trusts, AHS, and donors across the province share a commitment to community and local health care that has tremendous impact on patient experience and care. Our partner foundations raised $183.3 million in the past year. We are grateful for their dedication and support toward our shared goals of creating positive family- and patient-care experiences and outcomes.

Alberta Cancer Foundation: Raised $40.1 million

Every year, cyclists go for a spin in the Enbridge Ride to Conquer Cancer in support of the Alberta Cancer Foundation. In August 2015, team Tom Baker Cancer Conquerors raised more than $306,000 to go toward cancer clinical trials research, during the 240-km round trip from Canada Olympic Park through the Alberta foothills.

It's "two-bikes-up" for cancer research from Dr. Nigel Brockton, a research scientist and leader of the One Aim team in the Enbridge Ride to Conquer Cancer, left, and Michael Civitella, AHS Executive Director of Operational and Facility Development at the Tom Baker Cancer Centre.

The Alberta Cancer Foundation raises money to advance cancer prevention, treatment and care in all Alberta cancer sites such as the Cross Cancer Institute (Edmonton), the Tom Baker Cancer Centre (Calgary), the Jack Ady Cancer Centre (Lethbridge), Central Alberta Cancer Centre (Red Deer), Grande Prairie Cancer Centre, Medicine Hat Cancer Centre and smaller community cancer centres. The Alberta Cancer Foundation's goal is to deliver health care that Albertans expect through quality improvement and innovation, and a look at 2015-16 has shown improvements in many areas proving the foundation's goal is being achieved.

South Zone: 12 foundations raised $4.4 million

The heat is on for hungry patients at the Oyen Big Country Hospital with a new meal delivery system. Funded jointly by the Oyen & District Health Care Foundation and AHS, the delivery system keeps meals warm for longer periods of time. Sixty-four-year-old Don Ball says: "My meals were served hot and stayed warm."

AHS food services worker Sharol MacSwain serves Don Ball his meal using the new Aladdin TempRite meal delivery system at the Oyen Big Country Hospital. At Ball's side is his wife, Dianne.

Bassano & District Health Foundation, Bow Island & District Health Foundation, Brooks & District Health Foundation, Cardston & District Health Foundation, Chinook Regional Hospital Foundation, Crowsnest Pass Health Foundation, Fort Macleod & District Health Foundation, Medicine Hat & District Health Foundation, North County Health Foundation, Oyen & District Health Care Foundation, Taber and District Health Foundation, Windy Slopes Health Foundation.

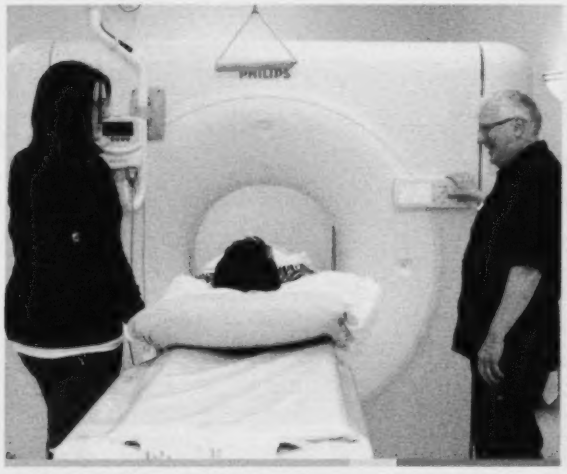
Calgary Zone: 11 foundations raised $66.7 million

The Vulcan Community Health Centre is cooking up some health and wellness by fostering a healthy start for families with its Healthy Moms, Healthy Babies program. The program offers monthly fresh food boxes subsidized by the Vulcan Health Care Auxiliary through the Vulcan County Health & Wellness Foundation.

Kerri Rombough and her two-year-old daughter Emma sort through a subsidized fresh food box, part of the Healthy Moms, Healthy Babies program in Vulcan.

Airdrie Health Foundation, Alberta Children's Hospital Foundation, Calgary Health Trust, Canmore & Area Health Care Foundation, Claresholm & District Health Foundation, EMS Foundation, High River District Health Care Foundation, Rosebud Health Foundation, Sheep River Health Trust, Strathmore District Health Foundation, Vulcan County Health & Wellness Foundation.

Central Zone: 15 foundations raised $8.5 million



Radiologist Dr. Timothy Kudel couldn't be happier with the new computed tomography (CT) scanner at the Wetaskiwin Community Health Centre, purchased by the Wetaskiwin Health Foundation for $1.2 million. "The new machine provides the technology to view sharper, crisper onscreen images that are processed faster, providing for quicker analyses and diagnoses for our patients," Dr. Kudel says. "This not only gives our patients peace of mind, but staff as well."

'Patient' Lesley Angeltvedt, supervisor of diagnostic imaging at the Wetaskiwin Community Health Centre, test drives the facility's new CT scanner, while medical radiation technician Kristina Johnson, left, and radiologist Dr. Timothy Kudel point to the control pads that operate the scanner.

Consort Hospital Foundation, Coronation Health Centre Foundation, David Thompson Health Trust, Daysland Hospital Foundation, Drayton Valley Health Services Foundation, Drumheller Area Health Foundation, Lacombe Health Trust, Ponoka and District Health Foundation, Provost & District Health Services Foundation, Red Deer Regional Health Foundation, Stettler Health Services Foundation, Tofield and Area Health Services Foundation, Viking Health Foundation, Wainwright and District Community Foundation, Wetaskiwin Health Foundation.

Edmonton Zone: 12 foundations raised $57.8 million

Donations come in many shapes and sizes – much like artwork – and touch the heart with the power of healing. Art's intrinsic value to health and well-being is priceless, and WestView Health Centre adult day program client Ernie Wakariuk says he enjoys seeing the work of painter RoseAnn Janzen on the facility's walls because it reminds him of family and home. "The picture of the farm field looks like the field where my dad and I used to stook wheat," says the 70-year-old Spruce Grove resident.

Showcasing a painting by artist RoseAnn Janzen, which was donated to the Tri-Community Health and Wellness Foundation for the WestView Health Centre in Stony Plain are, from left, site director Ellen Billay, RoseAnn Janzen, foundation Executive Director Sandy Iwaasa and foundation Chair Ralph Westwood.

Black Gold Health Foundation, Capital Care Foundation, Devon General Hospital Foundation, Fort Saskatchewan Community Hospital Foundation, Glenrose Rehabilitation Hospital Foundation, Mental Health Foundation, Royal Alexandra Hospital Foundation, Stollery Children's Hospital Foundation, Strathcona Community Hospital Foundation, Sturgeon Community Hospital Foundation, Tri-Community Health and Wellness Foundation, University Hospital Foundation.

North Zone: 17 foundations raised $5.8 million

The Queen Elizabeth II Hospital (QEII) in Grande Prairie welcomed its newest arrival in July 2015 – the Drager Isolette – a state-of-the-art warming incubator that provides a life-sustaining environment for critically ill, premature or below-average-weight newborns. The equipment comes thanks to $20,000 raised through the Grande Prairie Regional Hospital Foundation radiothon.

Dianne Sweetman, pediatrics and neonatal intensive care unit manager at the QEII Hospital poses with the unit's new Drager Isolette neonatal incubator.

Beaverlodge Hospital Foundation, Cold Lake Hospital Foundation Society, Fairview Health Complex Foundation, Grande Cache Hospital Foundation, Grande Prairie Regional Hospital Foundation, Grimshaw/Berwyn Hospital Foundation, Hinton Health Care Foundation, Hythe Nursing Home Foundation, Jasper Healthcare Foundation, Lac La Biche Regional Health Foundation, Northern Lights Health Foundation, Northwest Health Foundation, Peace River & District Health Foundation, Regional EMS Foundation, St. Paul and District Hospital Foundation, Swan Hills Hospital Foundation, Valleyview Health Centre Foundation.

Public Interest Disclosure (Whistleblower Protection) Act

On June 1, 2013, the provincial government enacted legislation surrounding the Public Interest Disclosure (Whistleblower Protection) Act (PIDA) and Regulations (the Act). The Act protects employees when making disclosures of certain kinds of wrongdoing they observe in the AHS workplace.

The purpose of the Act includes:

- facilitating the disclosure of wrongdoing.
- protecting those who make a disclosure from reprisal.
- implementing recommendations arising from investigations.
- promoting confidence in the public sector.

In 2009, AHS established a solid foundation for leading this work across the organization by approving the AHS Safe Disclosure/Whistleblower Policy and appointing a Chief Ethics & Compliance Officer, who, under the Act, is also the AHS Designated Officer for PIDA.

Over the past year, AHS has:

- Enhanced the internal processes and procedures to manage reports of wrongdoing in the new Ethical Conduct Governance Documents Policy Suite (and as in the PIDA Procedures and the Safe Disclosure/ Whistleblower Policy Frequently Asked Questions).
- Provided additional resources and ongoing training to managers and staff about PIDA and the internal disclosure process.
- Participated in the legislative review of PIDA.

In compliance with legislated reporting requirements, from April 1, 2015 to March 31, 2016, there have been no disclosures under PIDA to the AHS Designated Officer; as such, no AHS investigations are underway and no actions have been taken.

Of note: The AHS Designated Officer coordinates all PIDA disclosures pertaining to AHS, including those that may originate externally via the provincial PIDA Commissioner/ Office of the Ombudsman.

Surgical Contracts

AHS contracts services with multiple Non-Hospital Surgical Facilities (NHSF) to provide insured surgical services for dermatology, ophthalmology, oral maxillofacial, otolaryngology, plastic surgery and pregnancy terminations. The use of NHSFs enables AHS to obtain quality services to enhance surgical access and alleviate capacity pressures within AHS main operating rooms.

The Provincial NHSF Working Group was launched in May 2014. A provincial framework for NHSF business was developed including governance, quality measurement, incident reporting, and monitoring.

AHS determines if the contract is appropriate by assessing sustainability of the public system, access to services, patient safety, appropriateness, effectiveness, cost and public benefit. Contracts with NHSFs provide increased choice of service provider for patients and supplement the resources available in hospitals, while providing good value for public dollars.

The following table summarizes the contracts by service area for 2015-16:

Service Area	Number of Operators	Number of Procedures Performed
Dermatology - Edmonton Zone	1	17
Ophthalmology - Calgary Zone	5	16,447
Ophthalmology - Edmonton Zone	6	3,979
Ophthalmology - North Zone	1	887
Oral and Maxillofacial Surgery - Calgary Zone	8	847
Oral and Maxillofacial Surgery - Edmonton Zone	9	2,512
Otolaryngology (ENT) - Edmonton Zone	2	213
Plastic Surgery - Edmonton Zone	3	328
Pregnancy Termination - Calgary	1	5,015
Pregnancy Termination - Edmonton	1	6,172

Note: There are no surgical contracts with NHSFs in the South and Central Zones that fall under the *Health Care Protection Act* (Alberta).

AHS-Funded Facilities

Facility	Definition
Addiction	Addiction treatment facilities with beds and mats for clients with substance use and gambling problems. Includes detoxification, nursing care, assessment, counselling and treatment. Direct services provided by AHS as well as funded and contracted services. This also includes beds for Protection of Children Abusing Drugs (PChAD) program clients and residential beds funded through the Safe Communities Initiative.
Comm. MH	Community Mental Health support home programs, Canadian Mental Health Association community beds and other mental health community beds/spaces.
Standalone Psych	Standalone psychiatric facilities: 1. Alberta Hospital Edmonton (Edmonton) 2. Southern Alberta Forensic Psychiatric Centre (Calgary) 3. Centennial Centre for Mental Health and Brain Injury (CCMHBI) (Ponoka) 4. Claresholm Centre for Mental Health and Addictions (Claresholm) 5. Villa Caritas (Edmonton)
Hospital	Acute Care Hospitals are where active treatment is provided. They include medical, surgery, obstetrics, pediatrics, acute care psychiatric, NICU (neonatal intensive care level II and III), ICU (includes intensive care unit, coronary care unit, special care unit, etc.), sub-acute, restorative and palliative beds located in the hospital. • ***Urban*** hospitals are located in large densely populated cities and may provide access to tertiary and secondary level care. Some examples of tertiary level care include head and neck oncology, high risk perinatology and neonatology, organ transplantation, trauma surgery, high dose (cancer) radiation and chemotherapy, growth and puberty disorders, advanced diagnostics (e.g. MRI, PET, CT, Nuclear Medicine, Interventional Radiology) and tertiary level specialty clinic services. • ***Regional*** hospitals provide access to secondary level care medical specialists who do not have first contact with patients, for example, cardiologists, urologists, and orthopedic surgeons. In addition to providing general surgery services, these facilities provide specialist surgical services (e.g. orthopedics, otolaryngology, plastic surgery, gynecology) and advanced diagnostics (e.g. MRI, CT). • ***Community*** hospitals provide access to rural clinical services - Ambulatory, Emergency, Inpatient Medicine, Obstetrics and Surgery (includes Endoscopy). • ***Standalone Emergency Departments (ED)*** reflect facilities with an ED and access to lab, diagnostic imaging, out-patient and specialty clinics. They do not have acute care beds or inpatient services. • ***Ambulatory Endoscopy/Surgical Centre Hospitals (OP)*** reflect facilities providing ambulatory services including endoscopy and outpatient specialty clinics.
Sub-acute Care (SAC)	Sub-acute care is provided in an auxiliary hospital for the purpose of receiving convalescent and/or rehabilitation services, where it is anticipated that the patient will achieve functional potential to enable them to improve their health status and to successfully return to the community.
Palliative (PEOLC)	Palliative and End of Life Care (PEOLC) facilities are where a designated program or bed for the purpose of receiving palliative care services including end-of-life and symptom alleviation but are not located in an acute care facility. This includes community hospice beds.
Long-Term Care (LTC)	Long-term care is provided in nursing homes and auxiliary hospitals. It is reserved for those with unpredictable and complex health needs, usually multiple chronic and/or unstable medical conditions. Long-term care includes health and personal care services, such as 24-hour nursing care provided by registered nurses or licensed practical nurses.
Supportive Living (SL)	Supportive living includes comprehensive services, such as the availability of 24-hour nursing care (levels 3 or 4). Supportive Living 4-Dementia is also available for those individuals living with moderate to severe dementia or cognitive impairment. Albertans accessing supportive living services generally reside in lodges, retirement communities, or supportive living centres.
Cancer (Ca)	The tertiary, regional and community cancer treatment centres provide cancer care services to newly diagnosed and follow up patients. Services include radiation therapy, chemotherapy and supportive care. Cancer Care Services include assessments and examinations, supportive care, pain management, prescription of cancer- related medications, education, resource and support counselling and referrals to other cancer centres.

Facility	Definition
Ambulatory	• ***Urgent Care Centre (UCC)*** is a community-based service delivery site (non-hospital setting) where higher level assessment, diagnostic and treatment services are provided for unscheduled clients who require immediate medical attention for injuries /illnesses that require human and technical resources more intensive than what is available in a physicians' office or AACC unit. • ***Advanced Ambulatory Care Centre (AACC)*** is a community-based service delivery site (non-hospital setting) where assessment, diagnostic and treatment services are provided for unscheduled patients seeking immediate medical attention for non-life threatening illnesses, typically patients of lower acuity than those treated in a UCC or ED. • ***Community Ambulatory Care Centre (CACC)*** is a community-based service delivery site (non-hospital setting) primarily engaged in the provision of ambulatory care diagnostic and treatment services. This includes typically scheduled primary care for clients who do not require hospital outpatient emergency care or inpatient treatment. • ***Family Care Clinic (FCC)*** provides primary health care to people and their families in under-serviced areas of Alberta. • ***Public Health Centres*** include community health centre, community health clinics, district office, public health, public health centres. They provide services that are offered by public health nurses including immunization, health education/counselling/support for parents, health assessment and screening to identify health concerns, and referral to appropriate health care providers such as physicians, and community resources.

Facility by Zone

This section contains an overview of facilities that support health care throughout the province and the beds or spaces within them, broken down provincially and/or by zone.

Number of Facilities	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
Community Ambulatory Care						
Urgent Care Centres		5		1		6
Ambulatory Care Centres	2	1	2		2	7
Family Care Clinics		1		1	1	3
Public Health Centres	17	22	34	21	45	139
Addiction and Mental Health						
Addiction	5	13	5	9	7	39
Community Mental Health	3	10	2	10	1	26
Standalone Psychiatric		2	1	2		5
Acute Care						
Urban		5		5		10
Regional	2		1		2	5
Community	10	8	29	7	31	85
Standalone Emergency Departments	1			2	1	4
Ambulatory Endoscopy or Surgical Centre Hospital	1	1				2
TOTAL DESIGNATED HOSPITALS	**14**	**14**	**30**	**14**	**34**	**106**
Cancer Care						
Cancer Centres	2	3	5	1	6	17
Community-Based Care						
Long-Term Care & Supportive Living (3, 4, Dementia)	48	66 (53 contracted care sites*)	73	90 (58 contracted care sites*)	55	332 (111 Contracted Care sites*)
Community Hospice, Palliative & End-of-Life Care	2	8	1	5	4	20

* Contracted care sites reflect the number of personal care, special care and family care homes.

Provincial Overview of Community-Based Capacity

Seniors and other Albertans living with disability and chronic conditions deserve the best care and support possible, and to live with dignity and respect. Since March 2010, 5,247 net new continuing care beds have been added to the system. Continued growth in community and home care capacity is the key to efficient system flow in emergency departments, acute care and the community; it also allows patients to receive the most appropriate care in the most appropriate setting by the most appropriate care provider.

As of...	Long-Term Care (LTC)	Supportive Living (SL)	Total Continuing Care	Net New LTC & SL Beds	Net New Palliative Beds	Total Net New Continuing Care Beds
March 2010	14,429	5,089	19,518			
March 2011	14,569	6,104	20,673	1,155		1,155
March 2012	14,734	6,941	21,675	1,002		1,002
March 2013	14,553	7,979	22,532	857	20	877
March 2014	14,370	8,497	22,867	335		335
March 2015	14,523	9,219	23,742	875	6	881
March 2016	14,768	9,936	24,704	962	35	997
Total Net New Beds	**339**	**4,847**	**5,186**	**5,186**	**61**	**5,247**

Number of Continuing Care Facilities by Provider

As of March 31, 2016, there were 23,742 Long Term Care (LTC) and Supportive Living (SL) spaces staffed and in operation in the province in over 300 facilities. These facilities encompass AHS operated and AHS subsidiary (Carewest and CapitalCare), voluntary (non-profit includes Covenant, Good Samaritan, etc.), private (includes Extendicare, AgeCare, etc.) and Regional Health Authority (Lloydminster) ownership types. AHS has contracts with private and voluntary providers to provide publicly-funded health services, and AHS controls access to these spaces. AHS will continue to improve the system and access to care and supports in the community. Collaboration with our valued service providers is integral to this effort.

Continuing Care Facilities by Operator*	Number of Facilities as of March 31, 2016				
	Long Term Care (LTC)	Supportive Living (SL)	Campus of Care (LTC and SL)	Total Facilities	% of Total
AHS Operated / Subsidiaries	81	14	2	97	29%
Private	40	83	9	132	40%
Voluntary (non-profit)	31	60	10	101	30%
Regional Health Authority (RHA)	2	0	0	2	1%
Total Net New Beds	**293***	**4,847**	**5,140**	**5,140**	**100%**

*This excludes 111 Personal Care Homes which are considered Private Supportive Living and 20 community palliative / hospice facilities.

Number of Beds/ Spaces as of March 31, 2016	South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Provincial
Acute Care						
Acute Care	548	2,201	936	2,393	835	6,913
Psychiatric in Acute Care	72	274	50	224	34	654
Neonatal Intensive Care (NICU Level II and III)	17	126	17	130	10	300
Intensive Care (includes ICU, SCU, CCU, CVICU and PICU)	24	136	21	189	14	384
Sub-acute in Acute Care	9	32	32	22	0	95
Palliative beds in Acute Care*	10	29	49	20	24	132
ACUTE CARE SUBTOTAL	**680**	**2,798**	**1,105**	**2,978**	**917**	**8,478**
Sub-acute in Auxiliary Hospital (includes transition, rehab, community support beds, etc.)	24	280	0	168	18	490
TOTAL ACUTE AND SUB-ACUTE CARE	**704**	**3,078**	**1,105**	**3,146**	**935**	**8,968**
Continuing Care						
Auxiliary Hospital	248	1,072	1,419	2,232	639	5,610
Nursing Home	601	4,286	891	2,754	626	9,158
Long-Term Care Subtotal	**849**	**5,358**	**2,310**	**4,986**	**1,265**	**14,768**
Supportive Living Level 4 - Dementia	513	626	268	1,086	166	2,659
Supportive Living Level 4	1,009	1,487	748	2,111	384	5,739
Supportive Living Level 3	309	233	396	402	198	1,538
Supportive Living Subtotal	**1,831**	**2,346**	**1,412**	**3,599**	**748**	**9,936**
LONG-TERM CARE & SUPPORTIVE LIVING SUBTOTAL	**2,680**	**7,704**	**3,722**	**8,585**	**2,013**	**24,704**
Community Palliative and Hospice (out of hospital) PEOLC	20	121	10	79	13	243
TOTAL CONTINUING CARE (includes LTC, SL, restorative care and palliative care)	**2,700**	**7,825**	**3,732**	**8,664**	**2,026**	**24,947**
Addiction & Mental Health						
Psychiatric (standalone facilities)	0	141	330	484	0	955
Addiction Treatment	64	293	66	322	143	888
Community Mental Health	37	352	31	200	5	625
TOTAL ADDICTION & MENTAL HEALTH	**101**	**786**	**427**	**1,006**	**148**	**2,468**
Alberta Total	**3,505**	**11,689**	**5,264**	**12,816**	**3,109**	**36,383**

*Acute care palliative moved to community – no beds were closed. ** Sub-acute in auxiliary shifted to restorative care – no beds were closed.

South Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Bassano Health Centre	X	Bassano				4			8		12		
Crowsnest Pass Health Centre	X	Blairmore				16			58		74		
York Creek Lodge		Blairmore								20	20		
Bow Island Health Centre	X	Bow Island				10			20		30		
Pleasant View Lodge		Bow Island								20	20		
Brooks Health Centre	X	Brooks				37			15		52		
Orchard Manor		Brooks								25	25		
Sunrise Gardens		Brooks								84	84		
Cardston Health Centre	X	Cardston				19			12		31		
Chinook Lodge		Cardston								20	20		
Good Samaritan Lee Crest		Cardston								95	95		
Coaldale Health Centre	X	Coaldale				OP			44		44		
Sunny South Lodge		Coaldale								45	45		
Extendicare Fort MacLeod		Fort MacLeod							50		50		
Foothills Detox Centre		Fort MacLeod	14								14		
Fort MacLeod Health Centre	X	Fort MacLeod				4					4		
MacLeod Pioneer Lodge		Fort MacLeod								10	10		
Chinook Regional Hospital	X	Lethbridge				287					287		
Jack Ady Cancer Centre	X	Lethbridge	Co-located on same campus as Chinook Regional Hospital									Ca	
CMHA Crisis Beds		Lethbridge		5							5		
CMHA Laura House		Lethbridge		7							7		
Columbia Assisted Living		Lethbridge								50	50		
Edith Cavell Care Centre		Lethbridge							120		120		
Extendicare Fairmont Park		Lethbridge								140	140		
Golden Acres Lodge		Lethbridge								45	45		
Good Samaritan Park Meadows Village		Lethbridge								121	121		
Good Samaritan West Highlands		Lethbridge								100	100		
Legacy Lodge		Lethbridge								104	104		
SASHA Group Home		Lethbridge		25							25		
South Country Treatment Centre		Lethbridge	21								21		
Southern Alcare Manor		Lethbridge	13								13		
St Michael's Health Centre		Lethbridge					24	10	72	60	166		
St. Therese Villa		Lethbridge								200	200		
Youth Residential Services	X	Lethbridge	8								8		

South Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Good Samaritan Garden Vista		Magrath								35	35		
Magrath Health Centre	X	Magrath											CACC
Club Sierra		Medicine Hat							50	36	86		
Cypress View		Medicine Hat								45	45		
Good Samaritan South Ridge Village		Medicine Hat							80	46	126		
Leisure Way		Medicine Hat								17	17		
Meadow Lands		Medicine Hat								10	10		
Meadow Ridge Seniors Village		Medicine Hat								84	84		
Medicine Hat Recovery Centre	X	Medicine Hat	8								8		
Medicine Hat Regional Hospital	X	Medicine Hat				246					246		
Margery E. Yuill Cancer Centre	X	Medicine Hat	Co-located same campus Medicine Hat Regional Hospital									Ca	
Riverview Care Centre		Medicine Hat							118		118		
St. Joseph's Home - Carmel Hospice		Medicine Hat						10		10	20		
Sunnyside Care Centre		Medicine Hat							100	24	124		
The Wellington Retirement Residence		Medicine Hat								50	50		
Valleyview		Medicine Hat							30	5	35		
Milk River Health Centre	X	Milk River				ED			24		24		
Prairie Rose Lodge		Milk River								10	10		
Big Country Hospital	X	Oyen				10			30		40		
Piyami Health Centre	X	Picture Butte											CACC
Piyami Lodge		Picture Butte								20	20		
Piyami Place		Picture Butte								15	15		
Good Samaritan Vista Village		Pincher Creek								75	75		
Pincher Creek Health Centre	X	Pincher Creek				16			3		19		
Good Samaritan Prairie Ridge		Raymond								85	85		
Raymond Health Centre	X	Raymond				12			5		17		
Clearview Lodge		Taber								20	20		
Good Samaritan Linden View		Taber								105	105		
Taber Health Centre	X	Taber				19			10		29		
Total South Zone			**64**	**37**	**0**	**680**	**24**	**20**	**849**	**1,831**	**3,505**		

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Airdrie Regional Community Health Centre	X	Airdrie											UCC
Bethany Airdrie		Airdrie							74		74		
Mineral Springs Hospital		Banff				22			25		47		
Oilfields General Hospital	X	Black Diamond				15			30		45		
Agape Hospice		Calgary						20			20		
Alberta Children's Hospital	X	Calgary				141					141		
Alpha House		Calgary	40								40		
Approved Homes - Mental Health		Calgary		117							117		
Aspen Family and Community Network		Calgary	3	3							6		
Aventa Addiction Treatment for Women		Calgary	48								48		
Bethany Calgary		Calgary							446		446		
Bethany Harvest Hills		Calgary							60		60		
Beverly Centre Glenmore		Calgary							208		208		
Beverly Centre Lake Midnapore		Calgary							270		270		
Bow Crest Care Centre		Calgary							150		150		
Bow View Manor		Calgary							231		231		
Calgary Community Rehab Program		Calgary		6							6		
Canadian Mental Health Association		Calgary		123							123		
Canadian Mental Health Association (Hamilton House)		Calgary		8							8		
Canadian Mental Health Association (Robert's House)		Calgary		9							9		
Carewest Colonel Belcher	X	Calgary							175	30	205		
Carewest Dr. Vernon Fanning Centre	X	Calgary					98		191		289		
Carewest Garrison Green	X	Calgary							200		200		
Carewest George Boyack	X	Calgary							221		221		
Carewest Glenmore Park	X	Calgary					147				147		
Carewest Nickle House	X	Calgary								10	10		
Carewest Rouleau Manor	X	Calgary							77		77		
Carewest Royal Park	X	Calgary							50		50		
Carewest Sarcee	X	Calgary					35	15	85		135		
Carewest Signal Pointe	X	Calgary							54		54		
Centre of Hope - Salvation Army		Calgary	30								30		
Clifton Manor		Calgary							250		250		
Community Living Alternative Services Ltd - Complex Needs Client		Calgary		1							1		

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Community Living Alternatives for the Mentally Disabled Association (Community LAMDA)		Calgary		62							62		
East Calgary Health Centre	X	Calgary											FCC
Eau Claire Retirement Residence		Calgary								73	73		
Edgemont Retirement Residence		Calgary								31	31		
Enviros Wilderness School Association		Calgary	10								10		
Evanston Grand Village		Calgary								102	102		
Extendicare Cedars Villa		Calgary							248		248		
Extendicare Hillcrest		Calgary							112		112		
Father Lacombe Care Centre		Calgary							114		114		
Foothills Medical Centre	X	Calgary									1,095		
Fresh Start Recovery Centre		Calgary	1								1		
Glamorgan Care Centre		Calgary							52		52		
Holy Cross Manor		Calgary								100	100		
Hull Homes Detox/PChaD		Calgary	12								12		
Intercare at Millrise		Calgary							51		51		
Intercare Brentwood Care Centre		Calgary							236		236		
Intercare Chinook Care Centre		Calgary						14	214		228		
Intercare Southwood Care Centre		Calgary						24	225		249		
Kingsland Terrace		Calgary								24	24		
Mayfair Care Centre		Calgary							142		142		
McKenzie Towne Continuing Care Centre		Calgary							150		150		
McKenzie Towne Retirement Residence		Calgary								42	42		
Millrise Place		Calgary								40	40		
Monterey Place		Calgary								107	107		
Mount Royal Care Centre		Calgary							93		93		
Newport Harbour Care Centre		Calgary							127		127		
Oxford House		Calgary	23								23		
Personal Care Homes - Continuing Care		Calgary								223	223		
Peter Lougheed Centre	X	Calgary				543					543		
Prince of Peace Harbour		Calgary								32	32		
Prince of Peace Manor		Calgary								30	30		
Providence Care Centre		Calgary							94	56	150		
Recovery Acres		Calgary	13								13		

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Renfrew Recovery Centre	X	Calgary	40								40		
Richmond Road Diagnostic & Treatment Centre	X	Calgary				OP							
Rocky Ridge Retirement Community		Calgary								29	29		
Rockyview General Hospital	X	Calgary				602					602		
Rosedale Hospice		Calgary						7			7		
Rotary Flames House	X	Calgary						7			7		
Scenic Acres Retirement Residence		Calgary								26	26		
SCOPE Hunterview House		Calgary		1							1		
Seton Seniors Community		Calgary							59	252	311		
Sheldon M. Chumir Health Centre	X	Calgary											UCC
South Calgary Health Centre	X	Calgary											UCC
South Health Campus	X	Calgary				269					269		
Southern Alberta Foresenic Psychiatric Centre	X	Calgary			33						33		
St. Marguerite Manor		Calgary						26		102	128		
Sunridge Medical Gallery	X	Calgary											CACC
Sunrise Native Addiction Services Society		Calgary	24								24		
Tom Baker Cancer Centre	X	Calgary										Ca	
Walden Heights Seniors Community		Calgary							58	234	292		
Wentworth Manor/The Residence and The Court		Calgary							73	57	130		
Whitehorn Village		Calgary								53	53		
Wing Kei Care Centre		Calgary							145		145		
Wing Kei Greenview		Calgary								95	95		
Woods Homes CPU (Community Psychiatry Unit), YCSP (Youth Community Support Program); ENP (Exceptional Needs Program)		Calgary		22							22		
Youville Women's Residence		Calgary	1								1		
Canmore General Hospital	X	Canmore				21			23		44		
Bow Valley Community Cancer Centre	X	Canmore	Co-located on same campus as Canmore General Hospital									Ca	
Claresholm Centre for Mental Health and Addictions	X	Claresholm			108						108		
Claresholm General Hospital	X	Claresholm				16					16		
Lander Treatment Centre	X	Claresholm	48								48		
Willow Creek Continuing Care Centre	X	Claresholm							100		100		
Bethany Cochrane		Cochrane							78		78		

Calgary Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Cochrane Community Health Centre	X	Cochrane											UCC
Aspen Ridge Lodge		Didsbury								30	30		
Bethany Didsbury		Didsbury								100	100		
Didsbury District Health Services	X	Didsbury				16			21		37		
High River General Hospital	X	High River				27			50		77		
High River Community Cancer Centre	X	High River	Co-located on same campus as High River General Hospital									Ca	
Sunrise Village High River		High River								108	108		
Silver Willow Lodge		Nanton								38	38		
Foothills Country Hospice		Okotoks						8			8		
Okotoks Health and Wellness Centre	X	Okotoks											UCC
Revera Heartland		Okotoks								40	40		
Strafford Foundation Tudor Manor		Okotoks								152	152		
Agecare Sagewood Seniors Community		Strathmore							35	130	165		
Strathmore District Health Services	X	Strathmore				23					23		
Extendicare Vulcan		Vulcan							46		46		
Vulcan Community Health Centre	X	Vulcan				8			15		23		
Total Calgary Zone			**293**	**352**	**141**	**2,798**	**280**	**121**	**5,358**	**2,346**	**11,689**		

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Bashaw Care Centre	X	Bashaw											CACC
Bashaw Meadows		Bashaw								30	30		
Bentley Care Centre	X	Bentley							16		16		
Slim Thorpe Recovery Centre		Blackfoot	6								6		
Breton Health Centre	X	Breton							23		23		
Bethany Meadows		Camrose							65	30	95		
Faith House		Camrose								20	20		
Louise Jensen Care Centre		Camrose							65		65		
Memory Lane		Camrose								25	25		
Rosehaven Care Centre		Camrose							75		75		
St Mary's Hospital		Camrose				76					76		
St Mary's Hospital		Camrose	Co-located on same campus as St. Mary's Hospital									Ca	
Sunrise Village Camrose		Camrose								82	82		
Viewpoint		Camrose								20	20		
Our Lady of the Rosary Hospital		Castor				5			22		27		
Consort Hospital and Care Centre	X	Consort				5			15		20		
Coronation Hospital and Care Centre	X	Coronation				10			23	19	52		
Daysland Health Centre	X	Daysland				26					26		
Providence Place		Daysland								16	16		
Drayton Valley Hospital and Care Centre	X	Drayton Valley				36			50		86		
Drayton Valley Community Cancer Centre	X	Drayton Valley	Co-located on same campus as Drayton Valley Hospital and Care Centre									Ca	
Serenity House	X	Drayton Valley								12	12		
Sunrise Village Drayton Valley		Drayton Valley								16	16		
Drumheller Health Centre	X	Drumheller				37			96		133		
Drumheller Community Cancer Centre	X	Drumheller	Co-located on same campus as Drumheller Health Centre									Ca	
Grace House		Drumheller	5								5		
Hillview Lodge		Drumheller								36	36		
Eckville Manor House		Eckville								15	15		
Galahad Care Centre	X	Galahad							20		20		
Hanna Health Centre	X	Hanna				17			61		78		
Hardisty Health Centre	X	Hardisty				5			15		20		
Innisfail Health Centre	X	Innisfail				28			78		106		
Sunset Manor		Innisfail								101	101		
Islay Assisted Living	X	Islay								20	20		

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Killam Health Care Centre		Killam				5			45		50		
Royal Oak Manor		Lacombe								111	111		
Lacombe Hospital and Care Centre	X	Lacombe				35			75		110		
Lamont Health Care Centre		Lamont				15			105		120		
Westview Care Community		Linden							37		37		
Points West Living Lloydminster		Lloydminster								60	60		
Dr Cooke Extended Care Centre		Lloydminster							50		50		
Lloydminster Continuing Care Centre		Lloydminster							60		60		
Lloydminster Hospital		Lloydminster (Sask)				39					39		
Lloydminster Hospital		Lloydminster (Sask)	Co-located on same campus as Lloydminster Hospital									Ca	
Mannville Care Centre	X	Mannville							23		23		
Mary Immaculate Hospital		Mundare							30		30		
Eagle View Lodge		Myrnam								9	9		
Enviros Wilderness School (Shunda Creek)		Nordegg	10								10		
Olds Hospital and Care Centre	X	Olds				33			50		83		
Sunrise Encore Olds		Olds								60	60		
Sunrise Village Olds		Olds								20	20		
Centennial Centre for Mental Health & Brain Injury	X	Ponoka			330						330		
Northcott Care Centre (Ponoka)		Ponoka							73		73		
Ponoka Hospital and Care Centre	X	Ponoka				29			28		57		
Sunrise Village Ponoka		Ponoka								20	20		
Provost Health Centre	X	Provost				15			47		62		
Addiction Counselling & Prevention Services	X	Red Deer	5								5		
Bethany CollegeSide (Red Deer)		Red Deer							112		112		
Extendicare Michener Hill		Red Deer							220	60	280		
Kentwood Place	X	Red Deer		25							25		
Pines Lodge		Red Deer								20	20		
Red Deer Hospice		Red Deer						10			10		
Red Deer Regional Hospital Centre	X	Red Deer				370					370		
Central Alberta Cancer Centre	X	Red Deer	Co-located on same campus as Red Deer Regional Hospital									Ca	
Safe Harbour Society		Red Deer	40								40		
Villa Marie		Red Deer								100	100		

Central Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
West Park Lodge		Red Deer								36	36		
Rimbey Hospital and Care Centre	X	Rimbey				23			84		107		
Clearwater Centre		Rocky Mountain House							40	39	79		
Rocky Mountain House Health Centre	X	Rocky Mountain House				31					31		
Stettler Hospital and Care Centre	X	Stettler				26			50		76		
Points West Living Stettler		Stettler								88	88		
Sundre Hospital and Care Centre	X	Sundre				14			15		29		
Bethany Sylvan Lake		Sylvan Lake							40	21	61		
Sylvan Lake Community Health Centre	X	Sylvan Lake											CACC
Chateau Three Hills		Three Hills								15	15		
Three Hills Health Centre	X	Three Hills				21			24		45		
Tofield Health Centre	X	Tofield				16			50		66		
St. Mary's Health Care Centre		Trochu							28		28		
Two Hills Health Centre	X	Two Hills				27			56		83		
Heritage House		Vegreville								42	42		
Points West Living Century Park		Vegreville								40	40		
St Joseph's General Hospital		Vegreville				25					25		
Vegreville Care Centre	X	Vegreville							60		60		
Vegreville Manor		Vegreville								15	15		
Vermilion Health Centre	X	Vermilion				26			48		74		
Vermilion Valley Lodge		Vermilion								40	40		
Extendicare Viking		Viking							60		60		
Viking Health Centre	X	Viking				16					16		
Points West Living Wainwright		Wainwright								59	59		
Wainwright Health Centre	X	Wainwright				25			69		94		
Good Samaritan Good Shepherd Lutheran Home		Wetaskiwin								69	69		
Sunrise Village Wetaskiwin		Wetaskiwin								20	20		
Wetaskiwin Hospital and Care Centre	X	Wetaskiwin				69			107		176		
Wetaskiwin Meadows		Wetaskiwin								26	26		
Wetaskiwin Serenity House (Bosco)		Wetaskiwin		6							6		
Total Central Zone			**66**	**31**	**330**	**1,105**	**0**	**10**	**2,310**	**1,412**	**5,264**		

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Kipohtakawmik Elders Lodge		Alexander Reserve								13	13		
Place Beausejour		Beaumont								46	46		
Devon General Hospital	X	Devon				10			14		24		
Addiction Recovery Centre	X	Edmonton	42								42		
Alberta Hospital Edmonton	X	Edmonton			334						334		
Allen Gray Continuing Care Centre		Edmonton							156		156		
Allendale House		Edmonton		10							10		
Ambrose Place		Edmonton		28							28		
Anderson Hall	X	Edmonton		14							14		
Balwin Villa (Excel Society)		Edmonton								104	104		
CapitalCare Dickinsfield	X	Edmonton							275		275		
CapitalCare Dickinsfield Duplexes	X	Edmonton								14	14		
CapitalCare Grandview	X	Edmonton					34		147		181		
CapitalCare Kipnes Centre for Veterans	X	Edmonton							120		120		
CapitalCare Laurier House Lynnwood	X	Edmonton								80	80		
CapitalCare Lynnwood	X	Edmonton							284		284		
CapitalCare McConnell Place North	X	Edmonton								36	36		
CapitalCare McConnell Place West	X	Edmonton								36	36		
CapitalCare Norwood	X	Edmonton					114	23	68		205		
Churchill Retirement Community		Edmonton								35	35		
Cross Cancer Institute	X	Edmonton				55					55	Ca	
Devonshire Care Centre		Edmonton							132		132		
Devonshire Manor		Edmonton								58	58		
Donnelly House		Edmonton		8							8		
E4C Meadows Place		Edmonton		16							16		
E4C Our Place		Edmonton		10							10		
East Edmonton Health Centre	X	Edmonton											FCC
Edmonton Chinatown Care Centre		Edmonton							80	15	95		
Edmonton General Continuing Care Centre		Edmonton					20	26	449		495		
Edmonton People in Need #2 (SCH)		Edmonton								34	34		
Edmonton People In Need Batoma House		Edmonton								85	85		
Emmanuel Home		Edmonton								15	15		
Extendicare Eaux Claires		Edmonton							180		180		

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Extendicare Holyrood		Edmonton							74		74		
Garneau Hall		Edmonton								37	37		
George Spady Centre Society		Edmonton	73								73		
Glastonbury Village		Edmonton								49	49		
Glenrose Rehabilitation Hospital	X	Edmonton				244					244		
Good Sam. Dr. Gerald Zetter Care Centre		Edmonton							200		200		
Good Samaritan Millwoods Care Centre		Edmonton							60		60		
Good Samaritan Southgate Care Centre		Edmonton							226		226		
Good Samaritan Wedman House		Edmonton								30	30		
Good Samaritan Wedman Village Homes		Edmonton								30	30		
Grand Manor		Edmonton								56	56		
Grey Nuns Community Hospital		Edmonton				354					354		
Hardisty Care Centre		Edmonton							180		180		
Health First Strathcona	X	Edmonton											UCC
Henwood Treatment Centre	X	Edmonton	72								72		
House Next Door #1, 2, 3		Edmonton		24							24		
Innovative Housing - 114 Gravelle		Edmonton								93	93		
Innovative Housing - Villa Marguerite		Edmonton								230	230		
Jasper Place Continuing Care Centre		Edmonton							100		100		
Jellinek House		Edmonton	8								8		
Jubilee Lodge Nursing Home		Edmonton							156		156		
Laurel Heights		Edmonton								70	70		
Lewis Estates Retirement Residence		Edmonton								87	87		
Lifestyle Options Riverbend		Edmonton								18	18		
Lifestyle Options Terra Losa		Edmonton								77	77		
Lifestyle Options Whitemud		Edmonton								77	77		
McDougall House		Edmonton	11								11		
Miller Crossing Care Centre		Edmonton							155		155		
Misericordia Community Hospital		Edmonton				306					306		
Northeast Community Health Centre	X	Edmonton				ED							
Ottewell Lodge		Edmonton		38							38		
Our House		Edmonton	10								10		
Our Parents' Home		Edmonton								50	50		
Recovery Acres Edmonton		Edmonton	34								34		

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Riverbend Retirement Residence		Edmonton								38	38		
Rosedale at Griesbach		Edmonton								165	165		
Rosedale Estates		Edmonton								50	50		
Royal Alexandra Hospital	X	Edmonton				877					877		
Rutherford Heights Retirement Residence		Edmonton								89	89		
Saint Thomas Assisted Living Centre		Edmonton								138	138		
Salvation Army Grace Manor		Edmonton								87	87		
Salvation Army Stepping Stone Supportive Residence		Edmonton								50	50		
Shepherd's Care Ashbourne		Edmonton								26	26		
Shepherd's Care Greenfield		Edmonton								30	30		
Shepherd's Care Kensington		Edmonton							69	86	155		
Shepherd's Care Millwoods		Edmonton							147		147		
Shepherd's Care Vanguard		Edmonton								94	94		
Shepherd's Garden		Edmonton								45	45		
South Terrace Continuing Care Centre		Edmonton							107		107		
St. Joseph's Auxiliary Hospital		Edmonton						14	188		202		
St. Michael's Long Term Care Centre		Edmonton							153		153		
Stollery Children's Hospital	X	Edmonton				155					155		
Touchmark at Wedgewood		Edmonton							64		64		
Tuoi Hac - Golden Age Manor		Edmonton								91	91		
University of Alberta Hospital	X	Edmonton				680					680		
Venta Care Centre		Edmonton							148		148		
Villa Caritas		Edmonton			150						150		
Wild Rose Cottage		Edmonton								27	27		
Youth Stabilization & Residential Services	X	Edmonton	21								21		
Good Samaritan Society Pembina Village		Evansburg							40		40		
Fort Saskatchewan Health Centre	X	Fort Saskatchewan				36					36		
Rivercrest Care Centre		Fort Saskatchewan							85		85		
Extendicare Leduc		Leduc							79		79		
Leduc Community Hospital	X	Leduc				70					70		
Lifestyle Options Leduc		Leduc								74	74		
Salem Manor Nursing Home		Leduc							102		102		

Edmonton Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Aspen House	X	Morinville								74	74		
CapitalCare Strathcona	X	Sherwood Park							111		111		
CapitalCare Laurier House Strathcona	X	Sherwood Park								42	42		
CASA House		Sherwood Park		20							20		
Country Cottage Seniors Residence		Sherwood Park								26	26		
Sherwood Care		Sherwood Park							100		100		
Strathacona Community Hospital	X	Sherwood Park				ED							
Summerwood Village Retirement Residence		Sherwood Park								79	79		
Copper Sky Lodge		Spruce Grove								131	131		
Good Samaritan Spruce Grove Centre		Spruce Grove								30	30		
Citadel Care Centre		St. Albert							129		129		
Foyer Lacombe		St. Albert						10	12		22		
Citadel Mews West		St. Albert								68	68		
Poundmaker's Lodge Treatment Center - Youth Addiction (Safe-Com)		St. Albert	51								51		
Rosedale St Albert		St. Albert								70	70		
St. Albert Retirement Residence		St. Albert								72	72		
Sturgeon Community Hospital	X	St. Albert				168					168		
Youville Auxiliary Hospital (Grey Nuns) of St. Albert		St. Albert							232		232		
Good Samaritan George Hennig Place		Stony Plain								30	30		
Good Samaritan Stony Plain Care Centre		Stony Plain							126	30	156		
WestView Health Centre - Stony Plain Care Centre	X	Stony Plain				23		6	38		67		
Family Care Homes		Various								11	11		
Approved Mental Health Care Homes		Various		32							32		
Personal Care Homes		Various								247	247		
Special Care Homes		Various								92	92		
West Country Hearth		Villeneuve								32	32		
Total Edmonton Zone			**322**	**200**	**484**	**2,978**	**168**	**79**	**4,986**	**3,599**	**12,816**		

North Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Athabasca Healthcare Centre	X	Athabasca				27			23		50		
Extendicare Athabasca		Athabasca							50		50		
Barrhead Healthcare Centre	X	Barrhead				34					34		
Barrhead Community Cancer Centre	X	Barrhead	Co-located on same campus as Barrhead Healthcare Centre									Ca	
Dr. W.R. Keir - Barrhead Continuing Care Centre	X	Barrhead							100		100		
Mental Health Spaces		Barrhead											
Shepherd's Care Barrhead		Barrhead								42	42		
Beaverlodge Municipal Hospital	X	Beaverlodge				18					18		
Bonnyville Healthcare Centre		Bonnyville				33			30		63		
Bonnyville Community Cancer Centre		Bonnyville	Co-located same campus as Bonnyville Healthcare Centre									Ca	
Bonnyville Indian Metis Rehab Centre		Bonnyville	20								20		
Extendicare Bonnyville		Bonnyville							50		50		
Boyle Healthcare Centre	X	Boyle				20					20		
Cold Lake Healthcare Centre	X	Cold Lake				24			31		55		
Points West Living Cold Lake		Cold Lake								42	42		
Ridgevalley Seniors Home		Crooked Creek								15	15		
Wabasca/Desmarais Healthcare Centre	X	Desmarais				10					10		
Edson Healthcare Centre	X	Edson				22			50		72		
Parkland Lodge		Edson								10	10		
Elk Point Healthcare Centre	X	Elk Point				12			30		42		
Elk Point Heritage Lodge		Elk Point								10	10		
Fairview Health Complex	X	Fairview				25		1	66		92		
Fort McMurray Recovery Centre	X	Fort McMurray	16								16		
Northern Lights Regional Health Centre	X	Fort McMurray				105			31		136	Ca	
Pastew Place Detox Centre		Fort McMurray	11								11		
St. Theresa General Hospital	X	Fort Vermilion				26			8		34		
Fox Creek Healthcare Centre	X	Fox Creek				4					4		
Grande Cache Community Health Complex	X	Grande Cache				12					12		
Whispering Pines Seniors Lodge		Grande Cache								15	15		
Grande Prairie Care Centre		Grande Prairie							60	60	120		
Northern Addiction Centre	X	Grande Prairie	63								63		
Points West Living Grand Prairie		Grande Prairie						10	50	95	155		
Queen Elizabeth II Hospital	X	Grande Prairie				161	10			27	198		
Grande Prairie Care Centre	X	Grande Prairie	Co located same campus as QEII Hospital									Ca	

North Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
The Gardens at Emerald Park		Grande Prairie								15	15		
Youth Detoxification Services	X	Grande Prairie	4								4		
Grimshaw/Berwyn and District Community Health Centre	X	Grimshaw				ED		1	19		20		
Stone Brook		Grimshaw								56	56		
Action North Recovery Centre		High Level	13								13		
Northwest Health Centre	X	High Level				21			11		32		
High Prairie Health Complex	X	High Prairie				25					25		
J.B. Wood Continuing Care Centre	X	High Prairie							37		37		
Metis Indian Town Alcohol Association (MITAA Centre)		High Prairie	16								16		
Hinton Healthcare Centre	X	Hinton				23					23		
Hinton Community Cancer Centre	X	Hinton	Co-located same campus as Hinton Healthcare Centre									Ca	
Mountain View Centre		Hinton								52	52		
Hythe Continuing Care Centre	X	Hythe							31		31		
Jasper Alpine Summit Seniors Lodge		Jasper								16	16		
Seton - Jasper Healthcare Centre	X	Jasper				11					11		
Heimstaed Lodge		La Crete								54	54		
La Crete Continuing Care Centre	X	La Crete						1	22		23		
La Crete Health Centre	X	La Crete											AACC
William J. Cadzow - Lac La Biche Healthcare Centre	X	Lac La Biche				23			41		64		
Manning Community Health Centre	X	Manning				11			16		27		
Extendicare Mayerthorpe		Mayerthorpe							50		50		
Mayerthorpe Healthcare Centre	X	Mayerthorpe				25			30		55		
Pleasant View Lodge		Mayerthorpe								15	15		
Manoir du Lac		McLennan							22	35	57		
Sacred Heart Community Health Centre	X	McLennan				20					20		
Chateau Lac St. Anne		Onoway								15	15		
Peace River Community Health Centre	X	Peace River				31			40		71		
Peace River Community Cancer Centre	X	Peace River	Co-located same campus as Peace River Comm. Health Centre									Ca	
Points West Living Peace River		Peace River								42	42		
Radway Continuing Care Centre	X	Radway							30		30		
Rainbow Lake Health Centre		Rainbow Lake											CACC
Redwater Healthcare Centre	X	Redwater				14			7		21		
Points West Living Slave Lake		Slave Lake								45	45		

North Zone

Facility Name	Operated by AHS	Location	Addiction	Comm. MH	Standalone Psych	Hospital	Subacute	Palliative	LTC	SL	Total	Cancer	Ambulatory
Slave Lake Family Care Clinic	X	Slave Lake											FCC
Slave Lake Healthcare Centre	X	Slave Lake				24			20		44		
Vanderwell Lodge		Slave Lake								8	8		
George McDougall - Smoky Lake Healthcare Centre	X	Smoky Lake				12			23		35		
Smoky Lake Continuing Care Centre	X	Smoky Lake							28		28		
Central Peace Health Complex	X	Spirit River				12			16		28		
Extendicare St. Paul		St Paul							76		76		
St. Therese - St. Paul Healthcare Centre	X	St Paul				40			30		70		
St. Paul Abilities Network		St. Paul		5						6	11		
Swan Hills Healthcare Centre	X	Swan Hills				4					4		
Valleyview Health Centre	X	Valleyview				20			25		45		
Vilna Villa		Vilna								12	12		
Smithfield Lodge	X	Westlock								46	46		
Westlock Healthcare Centre	X	Westlock				46	8		112		166		
Spruce View Lodge		Whitecourt								15	15		
Whitecourt Healthcare Centre	X	Whitecourt				22					22		
Total North Zone			**143**	**5**	**0**	**917**	**18**	**13**	**1,265**	**748**	**3,109**		

AHS-Reported Beds Staffed & In Operation Summary as of March 31, 2016

Zone	Addiction and Mental Health			Acute/Sub-Acute Care		Continuing Care-Facility Living				Supportive Living (SL)				TOTAL CONTINUING CARE (LTC + SL)	TOTAL COMMUNITY BASED CARE (Includes PEOLC)	Total Beds
	Addiction	Community Mental Health	Psychiatric (Standalone Facility)	Acute Care	Sub-Acute (Non-Acute Care Facility)	Community Palliative & End of Life Care (PEOLC)	Auxiliary Hospital	Nursing Home	LONG TERM CARE SUBTOTAL (auxiliary + nursing home)	Level 3	Level 4	Level 4 Dementia	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)			
South	64	37	0	680	24	20	248	601	849	309	1,009	513	1,831	2,680	2,700	3,505
Calgary	293	352	141	2,798	280	121	1,072	4,286	5,358	233	1,487	626	2,346	7,704	7,825	11,689
Central	66	31	330	1,105	0	10	1,419	891	2,310	396	748	268	1,412	3,722	3,732	5,264
Edmonton	322	200	484	2,978	168	79	2,232	2,754	4,986	402	2,111	1,086	3,599	8,585	8,664	12,816
North	143	5	0	917	18	13	639	626	1,265	198	384	166	748	2,013	2,026	3,109
AHS TOTAL	**888**	**625**	**955**	**8,478**	**490**	**243**	**5,610**	**9,158**	**14,768**	**1,538**	**5,739**	**2,659**	**9,936**	**24,704**	**24,947**	**36,383**

Adjusted From the Annual Report Totals - Reported Beds Staffed & In Operation Summary as of March 31, 2015

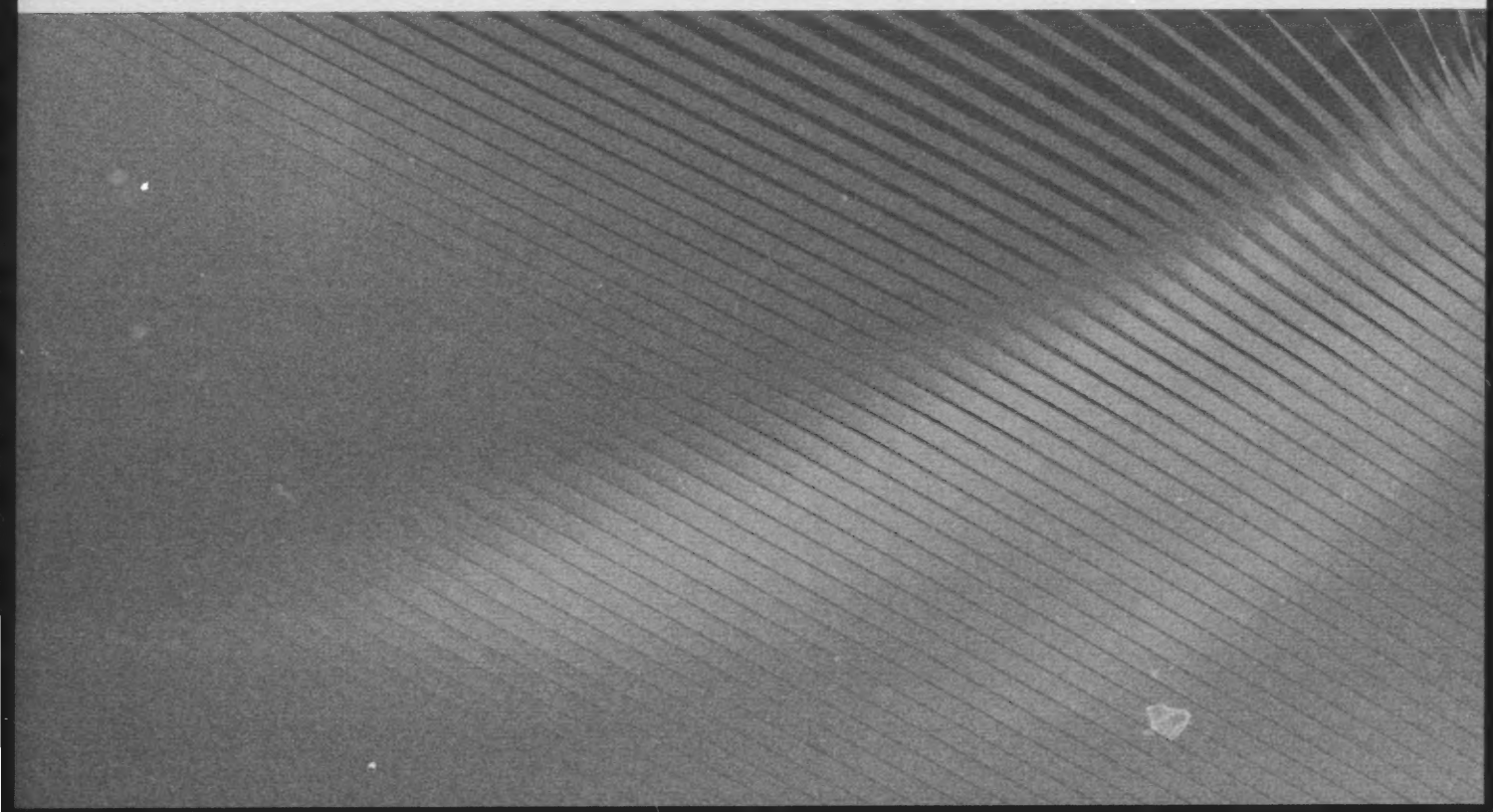
Zone	Addiction and Mental Health			Acute/Sub-Acute Care		Continuing Care-Facility Living				Supportive Living (SL)				TOTAL CONTINUING CARE (LTC + SL)	TOTAL COMMUNITY BASED CARE (Includes PEOLC)	Total Beds
	Addiction	Community Mental Health	Psychiatric (Standalone Facility)	Acute Care	Sub-Acute (Non-Acute Care Facility)	Community Palliative & End of Life Care (PEOLC)	Auxiliary Hospital	Nursing Home	LONG TERM CARE SUBTOTAL (auxiliary + nursing home)	Level 3	Level 4	Level 4 Dementia*	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)			
South	64	37	0	680	24	20	248	601	849	305	949	466	1,720	2,569	2,589	3,394
Calgary	296	336	141	2,832	280	95	1,072	4,079	5,151	233	1,180	499	1,912	7,063	7,158	11,043
Central	67	31	330	1,095	0	10	1,350	947	2,297	397	742	268	1,407	3,704	3,714	5,237
Edmonton	329	192	484	2,947	185	70	2,212	2,749	4,961	414	2,116	947	3,477	8,438	8,508	12,645
North	127	5	0	917	18	13	639	626	1,265	195	355	153	703	1,968	1,981	3,048
AHS TOTAL	**883**	**601**	**955**	**8,471**	**507**	**208**	**5,521**	**9,002**	**14,523**	**1,544**	**5,342**	**2,333**	**9,219**	**23,742**	**23,950**	**35,367**

Change from March 31, 2015 to March 31, 2016

Zone	Addiction and Mental Health			Acute/Sub-Acute Care		Continuing Care-Facility Living				Supportive Living (SL)				TOTAL CONTINUING CARE (LTC + SL)	TOTAL COMMUNITY BASED CARE (Includes PEOLC)	Total Beds
	Addiction	Community Mental Health	Psychiatric (Standalone Facility)	Acute Care	Sub-Acute (Non-Acute Care Facility)	Community Palliative & End of Life Care (PEOLC)	Auxiliary Hospital	Nursing Home	LONG TERM CARE SUBTOTAL	Level 3	Level 4	Level 4 Dementia	SUPPORTIVE LIVING SUBTOTAL (SL 3 + SL 4 + SL4D)			
South	0	0	0	0	0	0	0	0	0	4	60	47	111	111	111	111
Calgary	-3	16	0	-34	0	26	0	207	207	0	307	127	434	641	667	646
Central	-1	0	0	10	0	0	69	-56	13	-1	6	0	5	18	18	27
Edmonton	-7	8	0	31	-17	9	20	5	25	-12	-5	139	122	147	156	171
North	16	0	0	0	0	0	0	0	0	3	29	13	45	45	45	61
AHS TOTAL	**5**	**24**	**0**	**7**	**(17)**	**35**	**89**	**156**	**245**	**(6)**	**397**	**326**	**717**	**962**	**997**	**1,016**

Change in Bed Numbers by Zone from 2014-15 to 2015-16

Alberta Health Services

2015-16 Annual Report

Our appreciation and gratitude to all those who contributed to the 2015-16 Annual Report.